19-10651

IN THE

United States Court of Appeals

FOR THE ELEVENTH CIRCUIT

DARREN MICKELL, an individual,

Plaintiff-Appellant,

—v.—

BERT BELL / PETE ROZELLE NFL PLAYERS RETIREMENT PLAN, a welfare benefit plan,

Defendant-Appellee.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

APPENDIX
VOLUME VII OF VII

MICHAEL L. JUNK
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1701 Pennsylvania Avenue, NW,
Suite 1200
Washington, DC 20006
(202) 857-0620

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800 N. Magnolia Avenue, Suite 1201
Orlando, Florida 32803
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Attorneys for Defendant-Appellee

ALICIA PAULINO-GRISHAM
DI LAW GROUP
3201 West Commercial Boulevard,
Suite 227
Fort Lauderdale, Florida 33309
(954) 989-9000

Attorneys for Plaintiff-Appellant

Darren Mickell v. Bert Bell/Pete Rozelle NFL Players Retirement Plan

No. 19-10651-A

INDEX OF APPENDIX

6. To respond to any requests by the Plan or its Medical Director for clarification or for further information about the Player's capacities and limitations within ten (10) business days of receiving any such request.

7. To refrain from providing the Player with any form of medical treatment, any recommendation of possible courses of treatment or medications, or any advice about rehabilitation or vocational matters. Further, there should be no critique or commentary on prior treatment. Notwithstanding these rules, you should comply with any legal or ethical reporting or referral obligations that may apply to you, for example if you determine a Player is a threat to himself or to others or if state disclosure laws require you do inform the Player of serious conditions that you uncover.

8. To avoid any contact or communication with representatives of a Player (including, for example, agents and attorneys), other than for purposes of scheduling tests and evaluation, and to notify the Plan promptly of any such contact that is attempted.

9. To refuse any requests for information, including records or test results, received from Players or their representatives, to advise Players and their representatives to contact the Plan, and to notify the Plan promptly of such requests. The Plan will provide a copy of your reports to the Player upon receiving a request from the Player. Since this Agreement is between you and the Plan, the Plan is the owner of the Report.

10. To conduct each test and evaluation, and prepare each report, according to the highest applicable professional standards, without any bias or favoritism for or against any Player.

11. That you will not publicly or privately, except as required to evaluate and communicate a Players' qualifications under the Plan, discuss or comment on any aspect of the Plan, its procedures, or any Player, even if you no longer provide services to the Plan. This provision will survive termination of this Agreement.

12. To decline to evaluate on behalf of the Plan any Player whom you have evaluated or advised for a different purpose (that is, a purpose other than to evaluate his qualifications for disability benefits under the Plan), and to notify the Plan promptly of such prior services upon receiving a request from the Plan to evaluate the Player.

13. To notify the Plan immediately in the event a Player does not appear for a scheduled evaluation or is unable to schedule an evaluation in sufficient time to meet the deadlines set out above.

14. To retain records of the Player in complete confidence and in accordance with all applicable state and federal privacy requirements, and to destroy or return such records to the Plan Office upon completion of your final report to the Plan.

15. That you will not use the names, logos, or other marks of the NFL, the NFL Players Association, the Bert Bell/Pete Rozelle NFL Player Retirement Plan, or any of the NFL member clubs, or any reproduction of them, in any advertising, commercial, promotion, publicity, marketing, sales materials, or display materials utilized by you (including any materials published on a commercial on-line service, the World Wide Web or successor media).

16. To affirm that you have no actual or perceived conflict of interest, including, but not limited to, membership on the Injury Grievance Physician's panel, prior employment by an NFL team, or membership on the Second Opinion Panel of the CBA or any other panel established by the NFLPA or the NFL.

17. That no doctor-patient relationship will arise between you and the Player by virtue of your work under this contract.

In consideration for your services under this Agreement, the Plan will pay you a fee for each independent medical examination you conduct at the Plan's direction in the amount previously agreed upon. The Plan will provide the payment within ten (10) business days after receiving your completed narrative report and test results.

You agree and understand that you are an independent contractor. You will not be considered an employee of the Plan, its sponsors, or any of its related or affiliated entities for any reason. You specifically agree that the compensation provided to you under this Agreement constitutes adequate consideration for your rejection of any benefits the Plan or its sponsors extend to any of their employees. Further, the Plan will not withhold any tax from or pay any taxes with respect to fees or other amounts payable to you. You acknowledge and assume full responsibility and liability for income and employment taxes due with respect to fees received and agree to pay such taxes in a timely manner.

If you agree to the foregoing, please sign below and return this letter to the Plan Office.

Thank you for your cooperation. We look forward to working with you.

Sincerely,

Susan O. Cassidy, MD,JD
Medical Director

Attachment

Players Association, the Bert Bell/Pete Rozelle NFL Player Retirement Plan, [illegible] advertising, commercial, promotion, publicity, marketing, sales materials, or display materials utilized by you (including any materials published on a

16. To affirm that you have no actual or perceived conflict of interest, including, but not limited to, membership on the Injury Grievance Physician Appeal Panel of the CBA or any other panel established by the NFLPA or the NFL.

17. That no doctor-patient relationship will arise between you and the Player by virtue of your work under this contract.

In consideration for your services under this Agreement, the Plan will pay you a fee for each independent medical examination you conduct at the Plan's direction in the amount previously agreed upon. The Plan will provide the payment within ten (10) [illegible]

You agree and understand that you are an independent contractor. You will not be considered an employee of the Plan, its sponsors, or any of its related or affiliated [illegible] employment taxes due with respect to fees received and agree to pay such taxes in a timely manner.

If you agree to the foregoing, please sign below and return this letter to the Plan Office.

Thank you for your cooperation. We look forward to working with you.

Sincerely,

Susan O. Cassidy, MD,JD
Medical Director

Attachment

I have read and understood the foregoing. I agree to meet the standards described above in performing medical evaluations on behalf of the Plan.

Signature

CHAIM ARLOZOROFF

Name (Please Print)

2/5/2013

Date

Attachment A
To Agreement Between
Dr. Chamin Arlosoroff and Bert Bell/Pete Rozelle NFL Player Retirement Plan

The Plan will pay Dr. Chaim Arlosoroff a fee of $3,000 for each independent medical examination performed under the Agreement.

Dr. Barry McCasland

Bert Bell/Pete Rozelle NFL Player Retirement Plan
200 Saint Paul Street • Suite 2420 • Baltimore, Maryland 21202-2008
410-685-5069 • 800-638-3186 • Fax 410-783-0041

January 2, 2013

Barry John McCasland, MD, P.C.
3408 Northside Drive
Hapeville, GA 30354

Re: Independent Medical Examinations for
Bert Bell/Pete Rozelle NFL Player Retirement Plan

Dear Dr. McCasland:

Thank you for agreeing to serve the Bert Bell/Pete Rozelle NFL Player Retirement Plan ("Plan") by providing independent medical examinations of Players who seek disability benefits under the Plan. This letter ("Agreement") asks you to agree to provide your services according to certain standards. It is necessary that you agree to these standards, so that the Plan can refer Players to you for independent examinations.

You agree:

1. To complete all necessary tests and examinations no later than ten (10) business days after receiving a request from the Plan to examine a Player.

2. To determine the appropriate testing and examinations for the Player, taking into account the Player's claimed impairments and related conditions, as set forth in the Player's application or as advised by the Plan Office or the Plan's Medical Director.

3. That such tests and examinations shall include, without limitation, an examination of each Player by you personally, for as long as required, as well as any imaging and laboratory testing necessary to accurately evaluate the Player's impairments and conditions.

4. To personally review and evaluate any and all medical records and materials provided to you by the Plan. In the event you receive any materials directly from the Player or a representative of the Player, you will promptly forward a copy of such materials to the Plan.

5. To personally complete the Plan's Physician's Report Form as well as a comprehensive narrative report on each Player that specifies what records and materials you reviewed, what conclusions you reached, what evidence supports those conclusions, and what evidence, if any, supports a contrary conclusion.

6. To provide the Plan, by overnight mail and, upon request, by fax, the completed Physician's Report Form, your narrative report, and any test results no later than ten (10) business days after completing the tests and examinations.

7. To personally respond to any requests by the Plan or its Medical Director for clarification or for further information about the Player's capacities and limitations within ten (10) business days of receiving any such request.

8. To refrain from providing the Player with any form of medical treatment, any recommendation of possible courses of treatment or medications, or any advice about rehabilitation or vocational matters.

9. To avoid any contact or communication with representatives of a Player (including, for example, agents and attorneys), other than for purposes of scheduling tests and examination, and to notify the Plan promptly of any such contact that is attempted.

10. To refuse any requests for information, including records or test results, received from Players or their representatives, and to notify the Plan promptly of such requests.

11. To personally conduct each test and examination, and prepare each report, according to the highest applicable professional standards, without any bias or favoritism for or against any Player.

12. To refrain at all times from publicly discussing or commenting on any aspect of the Plan, its procedures, or any Player, even if you no longer provide services to the Plan. This provision will survive termination of this Agreement.

13. To decline to examine on behalf of the Plan any Player whom you have examined or advised for a different purpose (that is, a purpose other than to evaluate his qualifications for disability benefits under the Plan), and to notify the Plan promptly of such prior services upon receiving a request from the Plan to examine the Player.

14. To notify the Plan immediately in the event a Player does not appear for a scheduled examination or is unable to schedule an examination in sufficient time to meet the deadlines set out above.

15. To retain records of the Player in complete confidence and in accordance with all applicable state and federal privacy requirements and to return such records to the Plan Office six months after the examination.

16. To refrain from using the names, logos, or other marks of the NFL, the NFL Players Association, or the Bert Bell/Pete Rozelle NFL Player Retirement Plan or any of the NFL member clubs, or any reproduction of them, in any advertising, commercial, promotion, publicity, marketing, sales materials, or display materials utilized by you (including any materials published on a commercial on-line service, the World Wide Web or successor media).

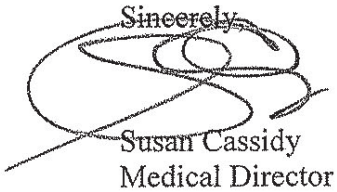
In consideration for your services under this Agreement, the Plan will pay you a fee for each independent medical examination you conduct at the Plan's direction in the amount previously agreed upon. The Plan also will reimburse you for any testing performed in connection with your independent medical examination. The Plan will provide the payment within ten (10) business days after receiving your completed narrative report and test results.

You agree and understand that you are an independent contractor. You will not be considered an employee of the Plan, its sponsors, or any of its related or affiliated entities for any reason. You specifically agree that the compensation provided to you under this Agreement constitutes adequate consideration for your rejection of any benefits the Plan or its sponsors extend to any of their employees. Further, Plan will not withhold any tax from or pay any taxes with respect to fees or other amounts payable to you. You acknowledge and assume full responsibility and liability for income and employment taxes due with respect to fees received and agree to pay such taxes in a timely manner.

If you agree to the foregoing, please sign below and return this letter to the Plan Office.

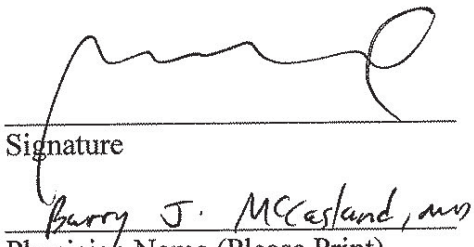
Thank you for your cooperation. We look forward to working with you.

Sincerely,



Susan Cassidy
Medical Director

I have read and understood the foregoing. I agree to meet the standards described above in performing independent medical examinations on behalf of the Plan.



Signature

Barry J. McCasland, MD

Physician Name (Please Print)

1/13/13

Date

Attachment A
To Agreement Between
Dr. Barry John McCasland and Bert Bell/Pete Rozelle NFL Player Retirement Plan

The Plan will pay Dr. Barry John McCasland a fee of $2,000 for each independent medical examination performed under the Agreement.

Dr. Stephen Macciocchi

Bert Bell/Pete Rozelle NFL Player Retirement Plan
200 Saint Paul Street • Suite 2420 • Baltimore, Maryland 21202-2008
410-685-5069 • 800-638-3186 • Fax 410-783-0041

March 19, 2012

RECEIVED
APR 09 2012
NFL PLAYER BENEFITS

Stephen Macciocchi, PhD ABPP
PO Box 15498
Atlanta, GA 30333

Re: Independent Neuropsychological Testing for
Bert Bell/Pete Rozelle NFL Player Retirement Plan

Dear Dr. Macciocchi:

Thank you for agreeing to serve the Bert Bell/Pete Rozelle NFL Player Retirement Plan ("Plan") by providing independent neuropsychological testing of Players who seek disability benefits under the Plan. This letter ("Agreement") constitutes a formal and binding agreement between you and the Plan. It is necessary that you agree to these service standards, so that the Plan can refer Players to you. This agreement supersedes any prior Agreement between you and the Plan.

You agree:

1. To complete all necessary tests and evaluations and deliver your completed report to the Plan Office as soon as possible, but no later than 30 calendar days after receiving a request from the Plan to evaluate a Player, and to send your report to the Plan Office by FedEx or fax, as necessary to meet the deadline.

2. To perform the appropriate testing and evaluations for the Player according to the Player's application or as advised by the Plan Office or the Plan's Medical Director.

3. That such tests and evaluations shall include, without limitation, an evaluation of each Player by you personally, for as long as required.

4. To personally review and evaluate any and all medical records and materials provided to you by the Plan. In the event you receive any materials directly from the Player or a representative of the Player, you will promptly forward a copy of such materials to the Plan.

5. To personally complete the Plan's Physician's Report Form as well as a comprehensive narrative report on each Player that specifies what records and materials you reviewed, what conclusions you reached, and what evidence supports those conclusions.

6. To respond to any requests by the Plan or its Medical Director for clarification or for further information about the Player's capacities and limitations within ten (10) business days of receiving any such request.

7. To refrain from providing the Player with any form of medical treatment, any recommendation of possible courses of treatment or medications, or any advice about rehabilitation or vocational matters. Further, there should be no critique or commentary on prior treatment. Notwithstanding these rules, you should comply with any legal or ethical reporting or referral obligations that may apply to you, for example if you determine a Player is a threat to himself or to others.

8. To avoid any contact or communication with representatives of a Player (including, for example, agents and attorneys), other than for purposes of scheduling tests and evaluation, and to notify the Plan promptly of any such contact that is attempted.

9. To refuse any requests for information, including records or test results, received from Players or their representatives, and to notify the Plan promptly of such requests.

10. To conduct each test and evaluation, and prepare each report, according to the highest applicable professional standards, without any bias or favoritism for or against any Player.

11. That you will not publicly or privately, except as required to evaluate and communicate a Players' qualifications under the Plan, discuss or comment on any aspect of the Plan, its procedures, or any Player, even if you no longer provide services to the Plan. This provision will survive termination of this Agreement.

12. To decline to evaluate on behalf of the Plan any Player whom you have evaluated or advised for a different purpose (that is, a purpose other than to evaluate his qualifications for disability benefits under the Plan), and to notify the Plan promptly of such prior services upon receiving a request from the Plan to evaluate the Player.

13. To notify the Plan immediately in the event a Player does not appear for a scheduled evaluation or is unable to schedule an evaluation in sufficient time to meet the deadlines set out above.

14. To retain records of the Player in complete confidence and in accordance with all applicable state and federal privacy requirements, and to destroy or return such records to the Plan Office upon completion of your final report to the Plan.

15. That you will not use the names, logos, or other marks of the NFL, the NFL Players Association, the Bert Bell/Pete Rozelle NFL Player Retirement Plan, or any of the NFL member clubs, or any reproduction of them, in any advertising, commercial, promotion, publicity, marketing, sales materials, or

display materials utilized by you (including any materials published on a commercial on-line service, the World Wide Web or successor media).

16. To affirm that you have no actual or perceived conflict of interest, including, but not limited to, membership on the Injury Grievance Physician's panel, prior employment by an NFL team, or membership on the Second Opinion Panel of the CBA or any other panel established by the NFLPA or the NFL.

17. To follow the attached Guidelines for use of Neuropsychological Test Technicians in Neuropsychological Evaluations when using test technicians to perform any portion of the neuropsychological testing or evaluation.

In consideration for your services under this Agreement, the Plan will pay you a fee for each independent neuropsychological evaluation you conduct at the Plan's direction in the amount previously agreed upon. The Plan will provide the payment within ten (10) business days after receiving your completed narrative report and test results.

You agree and understand that you are an independent contractor. You will not be considered an employee of the Plan, its sponsors, or any of its related or affiliated entities for any reason. You specifically agree that the compensation provided to you under this Agreement constitutes adequate consideration for your rejection of any benefits the Plan or its sponsors extend to any of their employees. Further, the Plan will not withhold any tax from or pay any taxes with respect to fees or other amounts payable to you. You acknowledge and assume full responsibility and liability for income and employment taxes due with respect to fees received and agree to pay such taxes in a timely manner.

If you agree to the foregoing, please sign below and return this letter to the Plan Office.

Thank you for your cooperation. We look forward to working with you.

Sincerely,

Sarah Gaunt
Plan Director

Susan O. Cassidy, MD, JD
Medical Director

Attachment

I have read and understood the foregoing. I agree to meet the standards described above in performing independent neuropsychological testing on behalf of the Plan.

Signature

STEPHEN MACCIOCCHI
Name (Please Print)

3-30-12
Date

Dr. George Canizares

NFL Player Benefits
200 Saint Paul Street • Suite 2420 • Baltimore, Maryland 21202-2008
410-685-5069 • 800-638-3186 • Fax 410-783-0041
NFL PLAYERS ASSOCIATION

March 31, 2009

George H. Canizares, M.D.
All Florida Orthopaedics
4600 4th Street North
St. Petersburg, FL 33703

Re: Independent Medical Examinations for
Bert Bell/Pete Rozelle NFL Player Retirement Plan

Dear Dr. Canizares:

Thank you for agreeing to serve the Bert Bell/Pete Rozelle NFL Player Retirement Plan ("Plan") by providing independent medical examinations of Players who seek disability benefits under the Plan. This letter ("Agreement") asks you to agree to provide your services according to certain standards. It is necessary that you agree to these standards, so that the Plan can refer Players to you for independent examinations.

You agree:

1. To complete all necessary tests and examinations no later than ten (10) business days after receiving a request from the Plan to examine a Player.

2. To determine the appropriate testing and examinations for the Player, taking into account the Player's claimed impairments and related conditions, as set forth in the Player's application or as advised by the Plan Office or the Plan's Medical Director.

3. That such tests and examinations shall include, without limitation, an examination of each Player by you personally, for as long as required, as well as any imaging and laboratory testing necessary to accurately evaluate the Player's impairments and conditions.

4. To personally review and evaluate any and all medical records and materials provided to you by the Plan. In the event you receive any materials directly from the Player or a representative of the Player, you will promptly forward a copy of such materials to the Plan.

5. To personally complete the Plan's Physician's Report Form as well as a comprehensive narrative report on each Player that specifies what records and materials you reviewed, what conclusions you reached, what evidence supports those conclusions, and what evidence, if any, supports a contrary conclusion.

6. To provide the Plan, by overnight mail and, upon request, by fax, the completed Physician's Report Form, your narrative report, and any test results no later than ten (10) business days after completing the tests and examinations.

7. To personally respond to any requests by the Plan or its Medical Director for clarification or for further information about the Player's capacities and limitations within ten (10) business days of receiving any such request.

8. To refrain from providing the Player with any form of medical treatment, any recommendation of possible courses of treatment or medications, or any advice about rehabilitation or vocational matters.

9. To avoid any contact or communication with representatives of a Player (including, for example, agents and attorneys), other than for purposes of scheduling tests and examination, and to notify the Plan promptly of any such contact that is attempted.

10. To refuse any requests for information, including records or test results, received from Players or their representatives, and to notify the Plan promptly of such requests.

11. To personally conduct each test and examination, and prepare each report, according to the highest applicable professional standards, without any bias or favoritism for or against any Player.

12. To refrain at all times from publicly discussing or commenting on any aspect of the Plan, its procedures, or any Player, even if you no longer provide services to the Plan. This provision will survive termination of this Agreement.

13. To decline to examine on behalf of the Plan any Player whom you have examined or advised for a different purpose (that is, a purpose other than to evaluate his qualifications for disability benefits under the Plan), and to notify the Plan promptly of such prior services upon receiving a request from the Plan to examine the Player.

14. To notify the Plan immediately in the event a Player does not appear for a scheduled examination or is unable to schedule an examination in sufficient time to meet the deadlines set out above.

15. To retain records of the Player in complete confidence and in accordance with all applicable state and federal privacy requirements and to return such records to the Plan Office six months after the examination.

16. To refrain from using the names, logos, or other marks of the NFL, the NFL Players Association, or the Bert Bell/Pete Rozelle NFL Player Retirement Plan or any of the NFL member clubs, or any reproduction of them, in any advertising, commercial, promotion, publicity, marketing, sales materials, or display materials utilized by you (including any materials published on a commercial on-line service, the World Wide Web or successor media).

In consideration for your services under this Agreement, the Plan will pay you a fee for each independent medical examination you conduct at the Plan's direction in the amount previously agreed upon. The Plan also will reimburse you for any testing performed in connection with your independent medical examination. The Plan will provide the payment within ten (10) business days after receiving your completed narrative report and test results.

You agree and understand that you are an independent contractor. You will not be considered an employee of the Plan, its sponsors, or any of its related or affiliated entities for any reason. You specifically agree that the compensation provided to you under this Agreement constitutes adequate consideration for your rejection of any benefits the Plan or its sponsors extend to any of their employees. Further, Plan will not withhold any tax from or pay any taxes with respect to fees or other amounts payable to you. You acknowledge and assume full responsibility and liability for income and employment taxes due with respect to fees received and agree to pay such taxes in a timely manner.

If you agree to the foregoing, please sign below and return this letter to the Plan Office.

Thank you for your cooperation. We look forward to working with you.

Sincerely,

Sarah Gaunt
Plan Director

I have read and understood the foregoing. I agree to meet the standards described above in performing independent medical examinations on behalf of the Plan.

Signature

GEORGE H. CANIZARES

Physician Name (Please Print)

4/4/2009

Date

Dr. Peter Dunne

Bert Bell/Pete Rozelle NFL Player Retirement Plan
200 Saint Paul Street • Suite 2420 • Baltimore, Maryland 21202-2008
410-685-5069 • 800-638-3186 • Fax 410-783-0041

July 24, 2014

Peter Dunne, M.D.
921 North Riverhills Drive
Tampa, FL 33617

Re: Independent Medical Examinations for
Bert Bell/Pete Rozelle NFL Player Retirement Plan

Dear Dr. Dunne:

Thank you for agreeing to serve the Bert Bell/Pete Rozelle NFL Player Retirement Plan ("Plan") by providing independent medical examinations of Players who seek disability benefits under the Plan. This letter ("Agreement") asks you to agree to provide your services according to certain standards. It is necessary that you agree to these standards, so that the Plan can refer Players to you for independent examinations.

You agree:

1. To complete all necessary tests and examinations as soon as administratively practicable, but no later than ten (10) business days after receiving a request from the Plan to examine a Player.

2. To determine the appropriate testing and examinations for the Player, taking into account the Player's claimed impairments and related conditions, as set forth in the Player's application or as advised by the Plan Office or the Plan's Medical Director.

3. That such tests and examinations shall include, without limitation, an examination of each Player by you personally, for as long as required, as well as any imaging and laboratory testing necessary to accurately evaluate the Player's impairments and conditions.

4. To personally review and evaluate any and all medical records and materials provided to you by the Plan. In the event you receive any materials directly from the Player or a representative of the Player, you will promptly forward a copy of such materials to the Plan.

5. To personally complete the Plan's Physician's Report Form as well as a comprehensive narrative report on each Player that specifies what records and materials you reviewed, what conclusions you reached, what evidence supports those conclusions, and what evidence, if any, supports a contrary conclusion.

6. To provide the Plan, by overnight mail and, upon request, by fax, the completed Physician's Report Form, your narrative report, and any test results as soon as administratively practicable, but no later than five (5) business days after completing the tests and examinations.

7. To personally respond to any requests by the Plan or its Medical Director for clarification or for further information about the Player's capacities and limitations as soon as administratively practicable, but no later than five (5) business days of receiving any such request.

8. To refrain from providing the Player with any form of medical treatment, any recommendation of possible courses of treatment or medications, or any advice about rehabilitation or vocational matters.

9. To avoid any contact or communication with representatives of a Player (including, for example, agents and attorneys), other than for purposes of scheduling tests and examination, and to notify the Plan promptly of any such contact that is attempted.

10. To refuse any requests for information, including records or test results, received from Players or their representatives, and to notify the Plan promptly of such requests.

11. To personally conduct each test and examination, and prepare each report, according to the highest applicable professional standards, without any bias or favoritism for or against any Player.

12. To refrain at all times from publicly discussing or commenting on any aspect of the Plan, its procedures, or any Player, even if you no longer provide services to the Plan. This provision will survive termination of this Agreement.

13. To decline to examine on behalf of the Plan any Player whom you have examined or advised for a different purpose (that is, a purpose other than to evaluate his qualifications for disability benefits under the Plan), and to notify the Plan promptly of such prior services upon receiving a request from the Plan to examine the Player.

14. To notify the Plan immediately in the event a Player does not appear for a scheduled examination or is unable to schedule an examination in sufficient time to meet the deadlines set out above.

15. To retain records of the Player in complete confidence and in accordance with all applicable state and federal privacy requirements and to return such records to the Plan Office six months after the examination.

16. To refrain from using the names, logos, or other marks of the NFL, the NFL Players Association, or the Bert Bell/Pete Rozelle NFL Player Retirement Plan or any of the NFL member clubs, or any reproduction of them, in any advertising, commercial, promotion, publicity, marketing, sales materials, or display materials utilized by you (including any materials published on a commercial on-line service, the World Wide Web or successor media).

In consideration for your services under this Agreement, the Plan will pay you a fee for each independent medical examination you conduct at the Plan's direction in the amount previously agreed upon. The Plan also will reimburse you for any testing performed in connection with your independent medical examination. The Plan will provide the payment within ten (10) business days after receiving your completed narrative report and test results.

You agree and understand that you are an independent contractor. You will not be considered an employee of the Plan, its sponsors, or any of its related or affiliated entities for any reason. You specifically agree that the compensation provided to you under this Agreement constitutes adequate consideration for your rejection of any benefits the Plan or its sponsors extend to any of their employees. Further, Plan will not withhold any tax from or pay any taxes with respect to fees or other amounts payable to you. You acknowledge and assume full responsibility and liability for income and employment taxes due with respect to fees received and agree to pay such taxes in a timely manner.

If you agree to the foregoing, please sign below and return this letter to the Plan Office.

Thank you for your cooperation. We look forward to working with you.

Sincerely,

Michael B. Miller
Plan Director

Attachment

I have read and understood the foregoing. I agree to meet the standards described above in performing independent medical examinations on behalf of the Plan.

Peter B. Dunne D

Signature

PETER B. DUNNE, MD.

Physician Name (Please Print)

8.17.2014

Date

Dr. Sutapa Ford

Bert Bell/Pete Rozelle NFL Player Retirement Plan
200 Saint Paul Street • Suite 2420 • Baltimore, Maryland 21202-2008
410-685-5069 • 800-638-3186 • Fax 410-783-0041

March 19, 2012

Sutapa Ford, PhD
103 Market Street
Chapel Hill, NC 27516

Re: Independent Neuropsychological Testing for
Bert Bell/Pete Rozelle NFL Player Retirement Plan

Dear Dr. Ford:

Thank you for agreeing to serve the Bert Bell/Pete Rozelle NFL Player Retirement Plan ("Plan") by providing independent neuropsychological testing of Players who seek disability benefits under the Plan. This letter ("Agreement") constitutes a formal and binding agreement between you and the Plan. It is necessary that you agree to these service standards, so that the Plan can refer Players to you. This agreement supersedes any prior Agreement between you and the Plan.

You agree:

1. To complete all necessary tests and evaluations and deliver your completed report to the Plan Office as soon as possible, but no later than 30 calendar days after receiving a request from the Plan to evaluate a Player, and to send your report to the Plan Office by FedEx or fax, as necessary to meet the deadline.

2. To perform the appropriate testing and evaluations for the Player according to the Player's application or as advised by the Plan Office or the Plan's Medical Director.

3. That such tests and evaluations shall include, without limitation, an evaluation of each Player by you personally, for as long as required.

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7. To refrain from providing the Player with any form of medical treatment, any recommendation of possible courses of treatment or medications, or any advice about rehabilitation or vocational matters. Further, there should be no critique or commentary on prior treatment. Notwithstanding these rules, you should comply with any legal or ethical reporting or referral obligations that may apply to you, for example if you determine a Player is a threat to himself or to others.

8. To avoid any contact or communication with representatives of a Player (including, for example, agents and attorneys), other than for purposes of scheduling tests and evaluation, and to notify the Plan promptly of any such contact that is attempted.

9. To refuse any requests for information, including records or test results, received from Players or their representatives, and to notify the Plan promptly of such requests.

10. To conduct each test and evaluation, and prepare each report, according to the highest applicable professional standards, without any bias or favoritism for or against any Player.

11. That you will not publicly or privately, except as required to evaluate and communicate a Players' qualifications under the Plan, discuss or comment on any aspect of the Plan, its procedures, or any Player, even if you no longer provide services to the Plan. This provision will survive termination of this Agreement.

12. To decline to evaluate on behalf of the Plan any Player whom you have evaluated or advised for a different purpose (that is, a purpose other than to evaluate his qualifications for disability benefits under the Plan), and to notify the Plan promptly of such prior services upon receiving a request from the Plan to evaluate the Player.

13. To notify the Plan immediately in the event a Player does not appear for a scheduled evaluation or is unable to schedule an evaluation in sufficient time to meet the deadlines set out above.

14. To retain records of the Player in complete confidence and in accordance with all applicable state and federal privacy requirements, and to destroy or return such records to the Plan Office upon completion of your final report to the Plan.

15. That you will not use the names, logos, or other marks of the NFL, the NFL Players Association, the Bert Bell/Pete Rozelle NFL Player Retirement Plan, or any of the NFL member clubs, or any reproduction of them, in any advertising, commercial, promotion, publicity, marketing, sales materials, or

display materials utilized by you (including any materials published on a commercial on-line service, the World Wide Web or successor media).

16. To affirm that you have no actual or perceived conflict of interest, including, but not limited to, membership on the Injury Grievance Physician's panel, prior employment by an NFL team, or membership on the Second Opinion Panel of the CBA or any other panel established by the NFLPA or the NFL.

17. To follow the attached Guidelines for use of Neuropsychological Test Technicians in Neuropsychological Evaluations when using test technicians to perform any portion of the neuropsychological testing or evaluation.

In consideration for your services under this Agreement, the Plan will pay you a fee for each independent neuropsychological evaluation you conduct at the Plan's direction in the amount previously agreed upon. The Plan will provide the payment within ten (10) business days after receiving your completed narrative report and test results.

You agree and understand that you are an independent contractor. You will not be considered an employee of the Plan, its sponsors, or any of its related or affiliated entities for any reason. You specifically agree that the compensation provided to you under this Agreement constitutes adequate consideration for your rejection of any benefits the Plan or its sponsors extend to any of their employees. Further, the Plan will not withhold any tax from or pay any taxes with respect to fees or other amounts payable to you. You acknowledge and assume full responsibility and liability for income and employment taxes due with respect to fees received and agree to pay such taxes in a timely manner.

If you agree to the foregoing, please sign below and return this letter to the Plan Office.

Thank you for your cooperation. We look forward to working with you.

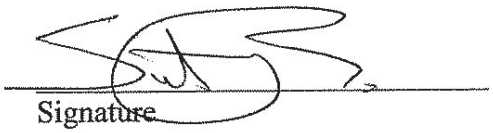
Sincerely,

Sarah Gaunt
Plan Director

Susan O. Cassidy, MD, JD
Medical Director

Attachment

I have read and understood the foregoing. I agree to meet the standards described above in performing independent neuropsychological testing on behalf of the Plan.



Signature

SUTAPA FORD

Name (Please Print)

4/1/12

Date

Dr. Raymond Faber

NFL Player Benefits
200 Saint Paul Street • Suite 2420 • Baltimore, Maryland 21202-2008
410-685-5069 • 800-638-3186 • Fax 410-783-0041
NFL PLAYERS ASSOCIATION

December 22, 2014

Raymond A. Faber, M.D.
17720 Corporate Woods Drive
San Antonio, TX 78259

Re: Independent Medical Examinations for
Bert Bell/Pete Rozelle NFL Player Retirement Plan
NFL Player Disability & Neurocognitive Benefit Plan

Dear Dr. Faber:

Thank you for agreeing to serve Bert Bell/Pete Rozelle NFL Player Retirement Plan and NFL Player Disability & Neurocognitive Benefit Plan (collectively, the "Plans") by providing independent medical examinations of Players who seek disability benefits under the Plans. This letter ("Agreement") asks you to agree to provide your services according to certain standards. It is necessary that you agree to these standards, so that the Plans can refer Players to you for independent examinations.

You agree:

1. To complete all necessary tests and examinations as soon as administratively practicable, but no later than ten (10) business days after receiving a request from the Plans to examine a Player.

2. To determine the appropriate testing and examinations for the Player, taking into account the Player's claimed impairments and related conditions, as set forth in the Player's application or as advised by the Plan Office or the Plans' Medical Director.

3. That such tests and examinations shall include, without limitation, an examination of each Player by you personally, for as long as required, as well as any imaging and laboratory testing necessary to accurately evaluate the Player's impairments and conditions.

4. To personally review and evaluate any and all medical records and materials provided to you by the Plans. In the event you receive any materials directly from the Player or a representative of the Player, you will promptly forward a copy of such materials to the Plans.

5. To personally complete the Plans' Physician's Report Form as well as a comprehensive narrative report on each Player that specifies what records and materials you reviewed, what conclusions you reached, what evidence supports those conclusions, and what evidence, if any, supports a contrary conclusion.

6. To provide the Plans, by overnight mail and, upon request, by fax, the completed Physician's Report Form, your narrative report, and any test results as soon as administratively practicable, no later than five (5) business days after completing the tests and examinations.

7. To personally respond to any requests by the Plans or their Medical Director for clarification or for further information about the Player's capacities and limitations within five (5) business days of receiving any such request.

8. To refrain from providing the Player with any form of medical treatment, any recommendation of possible courses of treatment or medications, or any advice about rehabilitation or vocational matters.

9. To avoid any contact or communication with representatives of a Player (including, for example, agents and attorneys), other than for purposes of scheduling tests and examination, and to notify the Plans promptly of any such contact that is attempted.

10. To refuse any requests for information, including records or test results, received from Players or their representatives, and to notify the Plans promptly of such requests.

11. To personally conduct each test and examination, and prepare each report, according to the highest applicable professional standards, without any bias or favoritism for or against any Player.

12. To refrain at all times from publicly discussing or commenting on any aspect of the Plans, its procedures, or any Player, even if you no longer provide services to the Plans. This provision will survive termination of this Agreement.

13. To decline to examine on behalf of the Plans any Player whom you have examined or advised for a different purpose (that is, a purpose other than to evaluate his qualifications for disability benefits under the Plan), and to notify the Plans promptly of such prior services upon receiving a request from the Plans to examine the Player.

14. To notify the Plans immediately in the event a Player does not appear for a scheduled examination or is unable to schedule an examination in sufficient time to meet the deadlines set out above.

15. To retain records of the Player in complete confidence and in accordance with all applicable state and federal privacy requirements and to return such records to the Plan Office six months after the examination.

16. To refrain from using the names, logos, or other marks of the NFL, the NFL Players Association, Bert Bell/Pete Rozelle NFL Player Retirement Plan, or the NFL Player Disability & Neurocognitive Benefit Plan or any of the NFL member clubs, or any reproduction of them, in any advertising, commercial, promotion, publicity, marketing, sales materials, or display materials utilized by you (including any materials published on a commercial on-line service, the World Wide Web or successor media).

In consideration for your services under this Agreement, the Plan will pay you a fee for each independent medical examination you conduct at the Plans' direction in the amount previously agreed upon. The Plans also will reimburse you for any testing performed in connection with your independent medical examination. The Plans will provide the payment within ten (10) business days after receiving your completed narrative report and test results.

You agree and understand that you are an independent contractor. You will not be considered an employee of the Plans, its sponsors, or any of its related or affiliated entities for any reason. You specifically agree that the compensation provided to you under this Agreement constitutes adequate consideration for your rejection of any benefits the Plan or its sponsors extend to any of their employees. Further, the Plans will not withhold any tax from or pay any taxes with respect to fees or other amounts payable to you. You acknowledge and assume full responsibility and liability for income and employment taxes due with respect to fees received and agree to pay such taxes in a timely manner.

If you agree to the foregoing, please sign below and return this letter to the Plan Office.

Thank you for your cooperation. We look forward to working with you.

Sincerely,

Michael M. Miller
Plan Director

I have read and understood the foregoing. I agree to meet the standards described above in performing independent medical examinations on behalf of the Plans.

Raymond Faber MD

Signature

Raymond Faber

Physician Name (Please Print)

December 24, 2014

Date

EXHIBIT C

NFL PLAYER BENEFITS
DISABILITY PLAN

200 St. Paul Street, Suite 2420
Baltimore, Maryland 21202
Phone 800.638.3186
Fax 410.783.0041

Via Federal Express

December 15, 2017

Mr. Darren Mickell
930 SW 88 Terrace
Pembroke Pines, FL 33025

Re: Application for Total and Permanent Disability Benefits
Initial Decision by Disability Initial Claims Committee

Dear Mr. Mickell:

On December 13, 2017, the Disability Initial Claims Committee ("Committee") of the NFL Player Disability & Neurocognitive Benefit Plan ("Plan") considered your application for total and permanent disability ("T&P") benefits. The Committee awarded you T&P benefits in the Inactive B category, with an effective date of September 1, 2017. By virtue of this award, you are entitled to receive a monthly benefit of $5,000 from the Plan. This letter describes the Committee's decision. Enclosed with this letter are the relevant Plan provisions cited below.

Discussion

Your renewed application for benefits was received on November 28, 2017 and was accompanied by an award of Social Security disability benefits.

On December 13, 2017, the Committee reviewed your application and concluded that you are eligible for Plan T&P benefits in light of your Social Security disability benefit award. The Committee made this determination because, under Plan Section 3.2(a), a Player will be deemed to be totally and permanently disabled under the Plan if he is eligible for Social Security disability benefits and receiving them at the time of his application for Plan T&P benefits.

The Committee determined that the Inactive B category of T&P benefits is appropriate because it found that you do not meet the requirements for the other three categories of T&P benefits. The Committee found that you do not qualify for the Inactive A category because your application for T&P benefits was received more than 15 years after the end of your last Credited Season. The Committee determined that you do not qualify for the Active Football or Active Nonfootball categories because there was no evidence of total and permanent disability during any conceivable "shortly after" period described in Plan Sections 3.4(a), 3.4(b), and 3.4(e). In addition, the Plan's limitation on classification in Section 3.9(a) precludes a finding of total and

permanent disability in any such "shortly after" period at this time. That limit states that you are conclusively presumed to be not totally and permanently disabled for any periods of time more than 42 months before November 28, 2017, the date your application was received.

The Committee determined that September 1, 2017 is the appropriate effective date because it is the first day of the month that is two months before the date your renewed application was received by the NFL Player Benefits Office. The Committee did not find that you had a mental incapacity that prevented you from filing an application sooner, so as to justify an earlier effective date under Section 3.10 of the Plan.

Tax Notice

Disability payments are taxable income. Enclosed is a Form W-4 tax withholding form for you to complete and return to this office. Payments may not commence until the completed tax withholding form is received by the NFL Player Benefits Office.

Appeal Rights

Enclosed with this letter is a copy of Plan Section 13.14, which governs your right to appeal the Committee's decision. You may appeal the Committee's decision to the Plan's Disability Board by filing a written request for review with the Disability Board at this office within 180 days of your receipt of this letter. You should also submit written comments, documents and any other information that you believe shows you qualify for these benefits. The Disability Board will take into account all available information, regardless of whether that information was available or presented to the Committee. You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits, including the governing Plan Document which can also be found at www.nflplayerbenefits.com. Please note that if the Disability Board reaches an adverse decision on review, you may then bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §1132(a).

If you have any questions, please contact the NFL Player Benefits Office.

Sincerely,

Meghan Pieklo
Benefits Coordinator
on behalf of the Disability Initial Claims Committee

cc: Alicia Paulino-Grisham

Enclosures

Relevant Plan Provisions

3.1 General Standard for Eligibility. An Article 3 Eligible Player will receive monthly Plan total and permanent disability benefits ("Plan T&P benefits") in the amount described in Section 3.6, for the months described in Sections 3.10 and 3.11, if and only if all of the conditions in (a), (b), (c), (d), and (e) below are met:

(a) The Player's written application, or similar letter initiating the administrative process, is received on or after January 1, 2015 and results in an award of Plan T&P benefits.

(b) The Player is not receiving monthly retirement benefits under Article 4 or Article 4A of the Bert Bell/Pete Rozelle Plan.

(c) At least one Plan neutral physician selected pursuant to Section 3.3(a) below must find, under the standard of Section 3.1(d) below, that (1) the Player has become totally disabled to the extent that he is substantially unable to engage in any occupation or employment for remuneration or profit, excluding any disability suffered while in the military service of any country, and (2) such condition is permanent. If no Plan neutral physician renders such a conclusion, then this threshold requirement is not satisfied, and the Player will not be eligible for and will not receive Plan T&P benefits, regardless of any other fact(s), statement(s), or determination(s), by any other person or entity, contained in the administrative record.

(d) After reviewing the report(s) of the Plan neutral physician(s) selected pursuant to Section 3.3(a) below, along with all other facts and circumstances in the administrative record, the Disability Initial Claims Committee or the Disability Board, as the case may be, must conclude, in its absolute discretion, that (1) the Player has become totally disabled to the extent that he is substantially prevented from or substantially unable to engage in any occupation or employment for remuneration or profit, but expressly excluding any disability suffered while in the military service of any country, and (2) that such condition is permanent. The following rules will apply:

i. The educational level and prior training of a Player will not be considered in determining whether such Player is "unable to engage in any occupation or employment for remuneration or profit."

ii. A Player will not be considered to be able to engage in any occupation or employment for remuneration or profit within the meaning of this Section 3.1 merely because such person is employed by the League or an Employer, manages personal or family investments, is employed by or

associated with a charitable organization, is employed out of benevolence, or receives up to $30,000 per year in earned income.

iii. A disability will be deemed to be "permanent" if it has persisted or is expected to persist for at least twelve months from the date of its occurrence, excluding any reasonably possible recovery period.

(e) The Player satisfies all other applicable requirements of this Article 3.

3.2 Social Security Standard for Eligibility.

(a) An Article 3 Eligible Player who is not receiving monthly pension benefits under Article 4 or 4A of the Bert Bell/Pete Rozelle Plan, who has been determined by the Social Security Administration to be eligible for disability benefits under either the Social Security disability insurance program or Supplemental Security Income program, and who is still receiving such benefits at the time he applies, will receive Plan T&P benefits in the amount described in Section 3.6, for the months described in Sections 3.10 and 3.11, unless four or more voting members of the Disability Board determine that such Player is receiving such benefits fraudulently and is not totally and permanently disabled. If his Social Security disability benefits are revoked, a Player will no longer be entitled to receive Plan T&P benefits by reason of this Section 3.2(a), effective as of the date of such revocation. However, if such Player establishes that the sole reason for the loss of his Social Security disability or Supplemental Security Income benefits was his receipt of benefits under this Plan, Plan T&P benefits will continue provided the Player satisfies the rules for continuation of benefits in Section 3.8(a).

(b) An Article 3 Eligible Player who elects to begin receiving pension benefits under Article 4 or 4A of the Bert Bell/Pete Rozelle Plan prior to his Normal Retirement Date, who is subsequently determined by the Social Security Administration to be eligible for disability benefits under either the Social Security disability insurance program or Supplemental Security Income program, who satisfies the other conditions of this paragraph, and who is still receiving such benefits at the time he applies, will receive Plan T&P benefits in the amount described in Section 3.6, for the months described in Sections 3.10 and 3.11, unless four or more voting members of the Disability Board determine that such Player is receiving such benefits fraudulently and is not totally and permanently disabled. To be eligible for benefits under this paragraph, the Player must apply for such Social Security disability benefits prior to his Normal Retirement Date, and the award of disability benefits by the Social Security Administration must occur prior to the Player's Normal Retirement Date. An award of disability benefits by the Social Security Administration after a Player's Normal Retirement Date that such Player was disabled as of a date prior to his Normal Retirement Date does not qualify such Player for Plan T&P benefits under this paragraph. If his Social Security disability

benefits are revoked, a Player will no longer be entitled to receive Plan T&P benefits by reason of this Section 3.2(b), effective as of the date of such revocation. However, if such Player establishes that the sole reason for the loss of his Social Security disability or Supplemental Security Income benefits was his receipt of benefits under this Plan, Plan T&P benefits will continue provided the Player satisfies the rules for continuation of benefits in Section 3.8(a).

3.3 Application Rules and Procedures. In addition to the requirements of Article 7 and Section 13.15 (claims procedures), Players must comply with the rules and procedures of this Section 3.3 in connection with an application for Plan T&P benefits.

(a) Medical Evaluations. Whenever the Disability Initial Claims Committee or the Disability Board reviews the application or appeal of any Player for Plan T&P benefits under Section 3.1 above, such Player may first be required to submit to an examination scheduled by the Plan with a neutral physician or physicians, or institution or institutions, or other medical professional or professionals, selected by the Disability Initial Claims Committee or the Disability Board and may be required to submit to such further examinations scheduled by the Plan as, in the opinion of the Disability Initial Claims Committee or the Disability Board, are necessary to make an adequate determination respecting his physical or mental condition.

Whenever the Disability Initial Claims Committee or the Disability Board reviews the application or appeal of any Player for Plan T&P benefits under Section 3.2 above, such Player may be required to submit to an examination scheduled by the Plan with a neutral physician or physicians, or institution or institutions, or other medical professional or professionals, selected by the Disability Initial Claims Committee or the Disability Board and may be required to submit to such further examinations scheduled by the Plan as, in the opinion of the Disability Initial Claims Committee or the Disability Board, are necessary to make an adequate determination respecting his physical or mental condition.

Any person refusing to submit to any examination will not be entitled to Plan T&P benefits. If a Player fails to attend an examination scheduled by the Plan, his application for Plan T&P benefits will be denied, unless the Player provided at least two business days advance notice to the NFL Player Benefits Office that he was unable to attend. The Plan will reschedule the Player's exam if two business days' advance notice is provided. The Player's application for Plan T&P benefits will be denied if he fails to attend the rescheduled exam, even if advance notice is provided. The Disability Initial Claims Committee or the Disability Board, as applicable, may waive the rule in the prior sentence if circumstances beyond the Player's control preclude the Player's attendance at the examination. A Player or his representative may submit to the NFL Player Benefits Office medical records or other materials for consideration by a neutral physician, institution, or medical

professional, except that any such materials received by the NFL Player Benefits Office less than 10 days prior to the date of the examination, other than radiographic tests, will not be considered by a neutral physician, institution, or medical professional.

3.4 Classification. Each Player who is determined to be eligible for Plan T&P benefits in accordance with Section 3.1 or 3.2 will be awarded benefits in one of the four categories below.

(a) Active Football. Subject to the special rules of Section 3.5, a Player will qualify for benefits in this category if the disability(ies) results from League football activities, arises while the Player is an Active Player, and causes the Player to be totally and permanently disabled "shortly after" the disability(ies) first arises.

(b) Active Nonfootball. Subject to the special rules of Section 3.5, a Player will qualify for benefits in this category if the disability(ies) does not result from League football activities, but does arise while the Player is an Active Player and does cause the Player to be totally and permanently disabled "shortly after" the disability(ies) first arises.

(c) Inactive A. Subject to the special rules of Section 3.5, a Player will qualify for benefits in this category if a written application for Plan T&P benefits or similar letter that began the administrative process that resulted in the award of Plan T&P benefits was received within fifteen (15) years after the end of the Player's last Credited Season. This category does not require that the disability arise out of League football activities.

(d) Inactive B. All Players who are determined to be eligible for Plan T&P benefits in accordance with Section 3.1 or 3.2 but who do not qualify for categories (a), (b), or (c) above will be awarded benefits in this category. This category does not require that the disability arise out of League football activities.

(e) "Shortly After" Defined. A Player who becomes totally and permanently disabled no later than six months after a disability(ies) first arises will be conclusively deemed to have become totally and permanently disabled "shortly after" the disability(ies) first arises, as that phrase is used in subsections (a) and (b) above, and a Player who becomes totally and permanently disabled more than twelve months after a disability(ies) first arises will be conclusively deemed not to have become totally and permanently disabled "shortly after" the disability(ies) first arises, as that phrase is used in subsections (a) and (b) above. In cases falling within this six- to twelve-month period, the Disability Board or the Disability Initial Claims Committee will have the right and duty to determine whether the "shortly after" standard is satisfied.

(f) "Arising out of League football activities" means a disablement arising out of any League pre-season, regular-season, or post-season game, or any combination thereof, or out of League football activity supervised by an Employer, including all required or directed activities. "Arising out of League football activities" does not include, without limitation, any disablement resulting from other employment, or athletic activity for recreational purposes, nor does it include a disablement that would not qualify for benefits but for an injury (or injuries) or illness that arises out of other than League football activities.

3.9 Other Classification Rules.

(a) Initial Classification. Classification of Plan T&P benefits under Section 3.4 will be determined by the Disability Board or the Disability Initial Claims Committee in all cases on all of the facts and circumstances in the administrative record. Determinations by the Social Security Administration as to the timing and causation of total and permanent disability are not binding and will be given less weight than contemporaneous medical evidence. In determining the appropriate classification of benefits for a Player who is eligible for Plan T&P benefits, it will be conclusively presumed that the Player was not totally and permanently disabled for all months or other periods of time more than forty-two months prior to the date the Disability Board receives a written application or similar request for Plan T&P benefits that begins the administrative process that results in the award of the benefit. This forty-two month limitation period will be tolled for any period of time during which such Player is found by the Disability Board or the Disability Initial Claims Committee to be physically or mentally incapacitated in a manner that substantially interferes with the filing of such claim.

(b) Reclassification. A Player who is awarded Plan T&P benefits will be deemed to continue to be eligible only for the category of benefits for which he first qualifies, unless the Player shows by evidence, found by the Disability Board or the Disability Initial Claims Committee to be clear and convincing, that the Player satisfies the conditions of eligibility for a benefit under a different category of Plan T&P benefits due to a new impairment that did not exist during the Player's original application, or due to an impairment that did exist but has become totally and permanently disabling following the decision on the original award of Plan T&P benefits. A Player will not be reclassified to Active Football or Active Nonfootball if his "shortly after" period (within the meaning of Section 3.3(e)) ended more than forty-two months before the date the Disability Board receives a written application or similar letter requesting such reclassification. A Player will not be reclassified to Inactive A if the Disability Board receives his written application or similar letter requesting such reclassification more than 18 years and six months after the end of the Player's last Credited Season. These limitation periods will be tolled for any period of time during which such Player is found by the Disability Board or the Disability Initial Claims Committee to be physically or mentally

incapacitated in a manner that substantially interferes with the filing of a claim for reclassification.

If a Player's request for reclassification is granted, the increase will be paid retroactive to the first day of the month that is two months prior to the date the written application or similar letter that began the administrative process that resulted in the reclassification was received. However, if an application was delayed because of the Player's mental incapacity, the award may be retroactive to the first day of a month that precedes the date of receipt of the application by up to thirty-six months, but only if and to the extent it is established that the mental incapacity caused the delay. In no event will the reclassification be retroactive to any date that precedes the date of receipt of the application by more than thirty-six months.

(c) Subsequent Periods of Total and Permanent Disability. A Player whose Plan T&P benefits terminate under this Plan or the Bert Bell/Pete Rozelle Plan will thereafter remain eligible to receive Plan T&P benefits in accordance with Section 3.4 should the Player experience a subsequent period of total and permanent disability. If the Player was awarded Plan T&P benefits under this Plan or the Bert Bell/Pete Rozelle Plan on or after September 1, 2011, any such subsequent total and permanent disability will be classified in accordance with the provisions of Section 3.4, without regard to the classification of any previous period of total and permanent disability. If the Player was awarded Plan T&P benefits under the Bert Bell/Pete Rozelle Plan before September 1, 2011, any such subsequent total and permanent disability will be classified in accordance with the provisions of the Bert Bell/Pete Rozelle Plan in effect immediately prior to September 1, 2011 (and not in accordance with Section 3.4), except that the dispute resolution procedures of section 9.3 of this Plan will apply.

3.10 Effective Date of Plan T&P Benefits. Plan T&P benefits will be paid retroactive to the first day of the month that is two months prior to the date a written application for Plan T&P benefits or similar letter that began the administrative process that resulted in an award of Plan T&P benefits was received. However, if an application was delayed because of the Player's mental incapacity, the award may be retroactive to the first day of a month that precedes the date of receipt of the application by up to thirty-six months, but only if and to the extent it is established that the mental incapacity caused the delay. In no event will Plan T&P benefits be retroactive to any date that precedes the date of receipt of the application by more than thirty-six months.

This paragraph applies where a Player originally applies for Plan T&P benefits under Section 3.1, and ultimately does not qualify for Plan T&P benefits under that standard, but during the processing of that application becomes eligible for Plan T&P benefits under Section 3.2 because he is determined by the Social Security Administration to be eligible for disability benefits under either the Social Security disability insurance program or Supplemental Security Income Program. In such cases, if the original application is still pending, the Player need not file a new application

for Plan T&P benefits; he need only provide satisfactory evidence of such Social Security determination to the Plan. In such cases, the date that the Player provides such evidence will be deemed to be the date of application for purposes of determining the category of benefits under Section 3.4. Further, in such cases, Plan T&P benefits will be paid retroactive to the first day of the month that is two months prior to the date of such Social Security determination, unless the NFL Player Benefits Office receives evidence of such Social Security determination more than six months after the date of the Social Security determination, in which case Plan T&P benefits will be paid retroactive to the first day of the month that is two months prior to the date such evidence is received by the NFL Player Benefits Office. For purposes of this paragraph, the date as of which the Social Security Administration deems a Player to have been disabled does not matter.

13.14 Claims Procedure. Except for Article 4 T&P benefits, each person must claim any disability benefits to which he believes he is entitled under this Plan by filing a written application with the Disability Board in accordance with the claims filing procedures established by the Disability Board, and such claimant must take such actions as the Disability Board or the Disability Initial Claims Committee may require. The Disability Board or the Disability Initial Claims Committee will notify such claimants when additional information is required. The time periods for decisions of the Disability Initial Claims Committee and the Disability Board in making an initial determination may be extended with the consent of the claimant.

A claimant's representative may act on behalf of a claimant in pursuing a claim for disability benefits or appeal of an adverse disability benefit determination only after the claimant submits to the Plan a signed written authorization identifying the representative by name. The Disability Board will not recognize a claimant's representative who is a convicted felon.

If a claim for disability benefits is wholly or partially denied, the Disability Initial Claims Committee will give the claimant notice of its adverse determination within a reasonable time, but not later than 45 days after receipt of the claim. This determination period may be extended twice by 30 days if, prior to the expiration of the period, the Disability Initial Claims Committee determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant of the circumstances requiring the extension of time and the date by which the Disability Initial Claims Committee expects to render a decision. If any extension is necessary, the notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. The claimant will be afforded at least 45 days within which to provide the specified information. If the Disability Initial Claims Committee fails to notify the claimant of its decision to grant or deny such claim within the time specified by this paragraph, the claimant may deem such claim to have been denied by the Disability Initial Claims Committee and the review procedures described below will become available to the claimant.

The notice of an adverse determination will be written in a manner calculated to be understood by the claimant and will set forth the following:

(1) the specific reason(s) for the adverse determination;

(2) reference to the specific Plan provisions on which the adverse determination is based;

(3) a description of additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary;

(4) a description of the Plan's claims review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA section 502(a) following an adverse determination on review;

(5) any internal rule, guideline, protocol, or other similar criterion relied on in making the determination (or state that such information is available free of charge upon request); and

(6) if the determination was based on a scientific or clinical exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's circumstances (or state that such explanation is available free of charge upon request).

The claimant will have 180 days from the receipt of an adverse determination to file a written request for review of the initial decision to the Disability Board.

The claimant will have the opportunity to submit written comments, documents, and other information in support of the request for review and will have access to relevant documents, records, and other information in his administrative record. The Disability Board's review of the adverse determination will take into account all available information, regardless of whether that information was presented or available to the Disability Initial Claims Committee. The Disability Board will accord no deference to the determination of the Disability Initial Claims Committee.

If a claim involves a medical judgment question, the health care professional who is consulted on review will not be the individual who was consulted during the initial determination or his subordinate, if applicable. Upon request, the Disability Board will provide for the identification of the medical experts whose advice was obtained on behalf of the Plan in connection with the adverse determination, without regard to whether the advice was relied upon in making the benefit determination.

Decisions by the Disability Board on review will be made no later than the date of the Disability Board meeting that immediately follows the Plan's receipt of the claimant's request for review, unless the request for review is received by the Plan within 30 days preceding the date of such meeting. In such case, the Disability Board's decision may be made by no later than the second meeting of the Disability Board following the Plan's receipt of the request for review. If special

circumstances require a further extension of time for processing, a determination will be rendered not later than the third meeting of the Disability Board following the Plan's receipt of the request for review. If such an extension of time is required, the Disability Board will notify the claimant in writing of the extension, describing the special circumstances and the date as of which the determination will be made, prior to the commencement of the extension.

The claimant will be notified of the results of the review not later than five days after the determination.

Any notification of an adverse determination on review will:

(1) state the specific reason(s) for the adverse determination;

(2) reference the specific Plan provision(s) on which the adverse determination is based;

(3) state that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;

(4) state that the claimant has the right to bring an action under ERISA section 502(a);

(5) disclose any internal rule, guidelines, or protocol relied on in making the determination (or state that such information will be provided free of charge upon request); and

(6) if the determination was based on a scientific or clinical exclusion or limit, contain an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's circumstances (or state that such explanation is available free of charge upon request).

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 15-62195-CIV-COHN/SELTZER

DARREN MICKELL,

Plaintiff,

vs.

BERT BELL/PETE ROZELLE
NFL PLAYERS RETIREMENT PLAN,

Defendant.

_____/

ORDER ON PARTIES' DISPOSITIVE MOTIONS

THIS CAUSE is before the Court upon Defendant's Motion for Judgment on the Administrative Record [DE 52] ("Defendant's Motion") and Plaintiff's Motion for Summary Judgment [DE 53] ("Plaintiff's Motion) (collectively, the "Motions"). The Court has considered the Motions, the parties' briefing on same, the administrative record in this case, and is otherwise advised in the premises. For the reasons set forth below, Defendant's Motion is granted and Plaintiff's Motion is denied.

I. BACKGROUND

Plaintiff Darren Mickell was a defensive lineman in the National Football League ("NFL") from 1992 to 2001. He alleges that he became disabled due to his years of playing professional football and has sought total and permanent disability ("T&P") benefits from Defendant the Bert Bell/Pete Rozelle NFL Player Retirement Plan (the "Plan"). Defendant denied his application for T&P benefits and, by way of this action, Plaintiff now seeks review of that decision under the Employment Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq*.

A. The Plan

The Plan provides retirement, disability, and related benefits to eligible NFL Players.[1] AR 6. It is governed by ERISA and the Labor Management Relations Act ("LMRA"), 29 U.S.C. § 141, *et seq*. As required by the LMRA, the Plan is jointly administered by employee and employer representatives. 29 U.S.C. § 186(c)(5)(B). The Plan's six-member Retirement Board (the "Board") consists of three members appointed by the NFL Management Council and three members appointed by the NFL Players Association—all of whom are former NFL players. AR 41. The Board is the Plan's "'named fiduciary' within the meaning of ERISA section 402(a)(2) and [it is] responsible for implementing and administering the Plan." Id.

The Plan grants the Board "full and absolute discretion, authority and power to interpret, control, implement, and manage" the Plan, AR 41, including discretionary authority to decide claims for benefits. AR 42, 45. Initially, claims for disability benefits are decided by the Plan's Disability Initial Claims Committee ("Committee"), but Players may appeal Committee decisions to the Board, which reviews and decides claims *de novo*. AR 44, 54.

Under the Plan's "General Standard" for determining total and permanent disability, a Player is entitled to T&P benefits if the Board finds that "he has become totally disabled to the extent that he is substantially prevented from or substantially unable to engage in any occupation or employment." AR 27. The General Standard contains an earned-income exception; it provides that "[a] Player will not be considered to be able to engage in any occupation or employment for remuneration or profit within

[1] Defined by the Plan as including "any person who is or was employed under a contract by an [NFL team] to play football in the [NFL.]" AR 12.

the meaning of this Section 5.2 merely because such person… receives up to $30,000 per year in earned income." Id.

When deciding a Player's application for T&P benefits, the Board may refer a Player for an evaluation with one or more physicians selected by the Plan. AR 28. The Plan refers to these physicians as "Plan Neutral Physicians." AR 49, 50. The Plan provides that "Neutral Physician reports… will be substantial factors" in the Board's decision-making. AR 50.

B. Plaintiff's Application for T&P Benefits

In September 2013, Plaintiff applied for T&P benefits based on a variety of orthopedic impairments. See AR 92 (completed application describing impairments to knees, hips, back, and shoulders). In his application, Plaintiff indicated that he was working full-time as a freight handler. AR 94. The Committee denied his application in light of his employment. AR 113. Plaintiff appealed on March 11, 2014, asserting that he earned "significantly less than the $30,000 per year threshold" and that "[a]s the direct result of injuries sustained while an active member of the [NFL], [he] sustained significant injuries resulting in symptoms, restrictions, and limitations which have prevented him from being able to substantially engage in any occupation or employment for remuneration or profit (up to $30,000.00 per year)." AR 780, 789. In response, the Board's counsel advised Plaintiff's counsel that because Plaintiff's annual income was less than $30,000, his claim would be re-presented to the Committee so that it could consider for the first time whether Plaintiff's impairments met the Plan's requirements for T&P benefits. AR 857.

On June 17, 2014, Plan Neutral orthopedist Dr. Chaim Arlosoroff evaluated Plaintiff. AR 766. The evaluation included a medical history, a physical examination, and radiographic imaging of Plaintiff's spine, shoulders, hips, knees, and ankles. AR 766-71. Dr. Arlosoroff did not, however, review Plaintiff's medical records.[2] Dr. Arlosoroff concluded that Plaintiff is not totally and permanently disabled and "can engage in any type of light to moderate duty work" but "should avoid employment which requires repetitive kneeling, squatting, and/or climbing stairs," "employment which requires climbing ladders or being in unprotected heights," and "positions which require repetitive heavy lifting, especially those above shoulder height." AR 771.

As noted, Plaintiff's counsel provided Defendant with copies of Plaintiff's medical records on June 17, 2014. AR 176. The records included reports from Plaintiff's physiatrist, Dr. Craig Lichtblau, and Plaintiff's psychologist, Dr. Mark Todd. In March 2014, Dr. Lichtblau had conducted a physical examination of Plaintiff, a functional capacity evaluation ("FCE"), an AMA impairment rating assessment, and a records review. AR 184-242. Dr. Litchblau stated that:

> It is my belief that this patient does not have the functional capacity to work 4 hours per day on an uninterrupted basis at this time. He should be in a job setting which allows him to take breaks to change positions from sit-to-stand/stand-to-sit frequently at will for positional comfort. He may sit, stand, and walk as tolerated. He may perform limited bending, limited reaching overhead, limited pushing and pulling. He should avoid kneeling, squatting, climbing unprotected heights, running, and jumping. His estimated physical demand characteristics from the hips-to-overhead position should remain at the light level, which is specifically defined by the Dictionary of Occupational Titles as lifting 20 lbs. infrequently and 10

[2] The parties blame each other for Dr. Arlosoroff's failure to review Plaintiff's medical records. Defendant asserts that Plaintiff's attorneys did not submit the first medical records in support of his application until the day of Dr. Arlosoroff's examination. DE 52 at 6. Plaintiff argues that Defendant mislead him into believing that Defendant had provided Dr. Arlosoroff with Plaintiff's medical records before the evaluation because a May 30, 2014 letter from Defendant to Plaintiff confirming the evaluation stated that "[y]our medical records and application have been sent to the above physician." DE 57 at n.7 (citing AR 162).

> lbs. or less frequently. This patient should always observe appropriate body mechanics which includes, but is not limited to, never bending at his waist while keeping his hips and knees extended.
>
> It should be understood this patient is going to suffer from acute, intermittent exacerbations of chronic pain and discomfort and, when he experiences these acute, intermittent exacerbations of pain and discomfort, he will have good days, bad days, and missed days of work.
>
> It is my medical opinion, as a Board Certified Physiatrist, this patient will be unable to maintain gainful employment in the competitive open labor market or in a sheltered environment with a benevolent employer, secondary to acute, intermittent exacerbations of chronic pain.

AR 204 (emphasis in original).

Dr. Todd had evaluated Plaintiff in April 2014 to assess his neurocognitive status. AR 252-66. Dr. Todd concluded that "[o]verall, [Plaintiff's] neuropsychological profile appears to provide evidence of a mild cognitive disorder." AR 265. Specifically, Dr. Todd explained that Plaintiff "clearly has less than expected memory for visual information as well as problems with rote verbal learning. He may have some slightly less than expected cognitive efficiency with mild slowing and perhaps some mild difficulties with visual perceptual analysis." Id. Dr. Todd also stated that Plaintiff's "mood symptoms are a prominent problem that could contribute to and may even account for his difficulties," and that "[t]he concern would be . . . that his problems may also be more reflective of a significant cognitive disorder related to a potential history of multiple concussive injuries." Ultimately, Dr. Todd concluded:

> [Plaintiff's] mood and behavior together with his physical problems and cognitive difficulties make competitive employment at this point quite difficult. It is recommended that he obtain assistance in trying to reduce some of the effects of these variables, which might make him able to participate in a competitive employment on a more regular basis. Unfortunately, these variables are likely to prohibit him from consistently attending work or completing work requirements.

AR 266.

On August 19, 2014, Plan Neutral neurologist Dr. Barry McCasland evaluated Plaintiff and reviewed certain of his medical records. AR 886-94. Dr. McCasland determined that Plaintiff has a "chronic headache disorder with mild headache burden," a "very mild cognitive impairment," and a "significant depression and anxiety disorder" which either accounts for, or contributes to, Plaintiff's mild cognitive impairment. AR 892. Nevertheless, Dr. McCasland indicated that Plaintiff was not totally and permanently disabled, and that he had "no limits from [a] neurologic standpoint." AR 887.

The next day, Plan Neutral neuropsychologist Dr. Stephen Macciocchi evaluated Plaintiff and reviewed certain of his medical records. AR 896-908. Dr. Macciocchi administered a number of psychological tests but expressed some concern about the reliability and validity of Plaintiff's results, particularly the results of his memory tests. AR 900-01. Dr. Macciocchi noted that:

> While there is self-report evidence Mr. Mickell is experiencing symptoms of major depression, and panic disorder, his MMPI-2RF is difficult to interpret due to symptom over-reporting on validity metrics, which raises concerns about the reliability of any self-report measures that do not have embedded symptom validity scales such as the BDI and BAI. Consequently, even though Mr. Mickell reports numerous clinically suggestive psychological health problems, the severity of his psychological health problems and implications for his ability to engage in competitive employment remains to be determined.

AR 903. Still, Dr. Macciocchi explained that "despite concerns about performance validity during the current assessment, Mr. Mickell did not evidence an abnormal number of low scores." AR 904. Plaintiff showed a decline in his memory test performance since his evaluation four months earlier by Dr. Todd, and Dr. Macciocchi

noted that "his memory test performance declined significantly on story memory tasks, but improved on list learning tasks." Id. Dr. Macciocchi opined that Plaintiff's "decline in story memory over such a brief period of time is most likely due to performance validity problems and/or exacerbation of psychiatric symptomatology." Id. Dr. Macciocchi concluded that:

> Even when considering validity issues, there is no current psychometric evidence Mr. Mickell cannot engage in gainful employment solely from a cognitive perspective. Whether Mr. Mickell's medical problems such as chronic pain or a psychiatric disorder, most likely major depression and panic disorder, would prevent him from working cannot be definitively determined by the current examination. There is clinically suggestive evidence he may have a major depressive disorder and a panic disorder, which could impair his ability to secure and maintain successful employment. Consequently, Mr. Mickell will need formal medical and psychiatric examinations to assess the reliability and significance of his physical/pain disorders and psychiatric condition. If obtained, a psychiatric examination must consider symptom validity and response bias in the context of any self-reported symptoms.

AR 904.

On September 8, 2014, the Committee again denied Plaintiff's application for T&P benefits. AR 916-17. Rather than denying his application solely due to his employment, as they had before, this time the Committee relied upon the conclusions of Dr. Arlosoroff, Dr. McCasland, and Dr. Macciocchi that Plaintiff was not totally and permanently disabled and denied his application on that basis. Id. In March 2015, Plaintiff formally appealed the Committee's decision. AR 934-1173. On appeal, Plaintiff was referred for additional evaluations with three new Plan Neutral Physicians.

On April 14, 2014, Plan Neutral orthopedist Dr. George Canizares evaluated Plaintiff and reviewed certain of his medical records. AR 1252-58. Dr. Canizares opined that Plaintiff suffered from:

1. Cervical DJD early C4-6 with C5-6 central disc herniation and C6-7 central disc herniation.
2. Lumbar broad based disc herniation, L4-5 and L5-S 1.
3. Bilateral shoulder moderate ac joint DJD, status post left shoulder distal clavicle resection with early DJD left shoulder.
4. Right hand fifth digit PIP contracture. Range of motion 30-90 degrees.
5. Right hip anterior labral tear per MRI. No obvious degenerative changes per the x-rays with decreased range of motion.
6. Bilateral knee patellofemoral DJD, moderate.

AR 1258. Dr. Canizares concluded that:

> [U]nder the circumstances, it is my feeling that this gentleman probably can conduct himself in a light duty work capacity. This job would require him to alternate sitting and standing and walk short distances. He can also drive. I do not feel he is able to conduct himself in any capacity beyond that due to his current orthopedic illness[es] which include his neck and back, which have evidence of degenerative herniated disc, shoulders with some early degenerative changes, his right hip with a labral tear, and his bilateral knees with moderate patellofemoral DJD.

Id.

The next day, Plan Neutral neurologist Dr. Peter Dunne evaluated Plaintiff and reviewed certain of his medical records. AR 1224-39. Dr. Dunne noted that Plaintiff's "major problems appear to be orthopedic," but agreed with Dr. Todd that Plaintiff has a "mild cognitive disorder." AR 1226. Dr. Dunne conceded that with respect to Plaintiff's cognitive disorder, "[i]t is hard to tell . . . what is depression and what is possible cognitive damage due to head trauma." Id. Still, Dr. Dunne concluded that "[n]eurologically Mr. Mickle [sic] has no deficits other than absent ankle jerks" and that "[h]e may have mild cognitive problems but they should not impact neurologically his employability." Id. Specifically, Dr. Dunne opined that Plaintiff could engage in sedentary employment that did not involve heavy lifting. AR 1225.

On April 27, 2014, Plan Neutral neuropsychologist Sutapa Ford evaluated Plaintiff, administered a number of psychological tests, and reviewed certain of his medical records. AR 1260-72. Like Dr. Macciocchi, Dr. Ford expressed concern about the validity of Plaintiff's scores. She reported that "Mr. Mickell failed all free-standing and embedded validity scores, performing at levels suggestive of significant exaggeration." AR 1268. While Dr. Ford noted that "this may be due to elevated psychiatric distress and pain," she stated that "the possibility of intentional exaggeration of symptoms cannot be entirely ruled out." Id. Regardless, Dr. Ford explained that:

> Despite poor performance on validity measures, cognitive scores were generally intact to mildly impaired. Comparison of Mr. Mickell's test scores to the August 2014 scores revealed consistency in performance across time. Mr. Mickell displayed mild fluctuations in test performance which is expected as part of normal variance in clinical scores. It is also common as his performance is likely influenced by psychiatric dysfunction, poor effort, pain or some combination thereof. Psychological testing revealed major depression and significant anxiety with evidence of symptom exaggeration.
>
> From a neurocognitive standpoint, there is insufficient evidence supporting the notion that Mr. Mickell is incapable of full-time employment as his scores are generally intact or mildly diminished. More significant to his functional capacity is psychiatric dysfunction, and it is therefore recommended that Mr. Mickell undergo a thorough psychiatric assessment which includes validity testing and formal assessment of response biases. Mr. Mickell's self-reported cognitive complaints are likely secondary to other factors, rather than neurological dysfunction, and may therefore improve with targeted treatment.

Id.

At its quarterly meeting on May 14, 2015, the Board reviewed Plaintiff's appeal and decided to refer Plaintiff to a Plan Neutral psychiatrist. AR 1324. Before that evaluation occurred, Plaintiff was evaluated by a psychologist of his own choosing, Peggy Vermont, on June 10, 2015. AR 1330-42. Ms. Vermont reported that "it appears

that Mr. Mickell is suffering from significant mental health symptoms that are impeding his social, emotional, and occupational functioning" and that "[d]ue to the severity of his mood and anxiety symptoms, Mr. Mickell is not deemed employable at this time." AR 1341.

On July 7, 2015, Plan Neutral psychiatrist Dr. Raymond Faber evaluated Plaintiff. AR 1346-51. Dr. Faber explained that "[b]ecause [Plaintiff] had had extensive neuropsychological testing, [he] saw no need to formally assess his cognition given his vocabulary and cogent thought." AR 1351. Dr. Faber diagnosed Plaintiff with "[d]epression and anxiety not otherwise specified," but stated that he did not consider Plaintiff's psychological difficulties "to rise to a level that precludes some kind of employment," such as "assist[ing] in sports program[s] for youths." AR 1347, 1351.

On July 29, 2015, Plaintiff was evaluated by another psychologist of his own choosing, Rosa Gonzalez, who diagnosed him with depression and anxiety and opined that as a result of his cognitive and emotional impairments, he "is unable to engage in any occupation." AR 1358-59. Still, Ms. Gonzalez explained that "[w]ith medication and regular therapy [Plaintiff] should be able to cope with his anxiety and depression to the point where he can attempt to return to work." AR 1359.

On August 19, 2015, the Board reviewed all of the materials referenced above and the arguments submitted by Plaintiff's counsel and unanimously denied his application for T&P benefits. AR 1365-67; 1370-74. Specifically, the Board explained to Plaintiff that:

> After considering all of the record evidence, the Retirement Board determined that there is substantial evidence to conclude that you are not totally and permanently disabled within the meaning of Section 5.2(a) of the Plan. The Retirement Board based this conclusion primarily upon the

> reports of the Plan's seven (7) neutral physicians, all of whom found that you are not totally and permanently disabled by your orthopedic, neurological, cognitive, and/or psychiatric impairments. For this reason, the Retirement Board denied your appeal.
>
> The Retirement Board reached its decision despite the presence of potentially conflicting medical evidence in the record. As noted above, Sections 8.2 and 8.9 of the Plan give the Retirement Board "full and absolute discretion" to determine the relative weight to give information in the administrative record. The Retirement Board noted that some of the evidence you submitted indicated you have certain impairments but did not directly address whether you are totally and permanently disabled (i.e., unemployable) due to those impairments. The Retirement Board considered such evidence, but placed less weight on it compared to other evidence that did directly address the issue of whether you are able to work. As for the evidence that did squarely address the issue, the Retirement Board had more confidence in the reports of the Plan's neutral physicians. The Plan's neutral physicians are instructed to evaluate Players fairly, without bias for or against the Player, and they typically have experience evaluating Players and other professional athletes. (For these reasons, the reports from the Plan's neutral physicians are uniformly accepted and relied upon by both the members of the Retirement Board appointed by the NFL and those appointed by the NFL Players Association.) Here, the Retirement Board also noted that none of the Plan's neutral physicians found you to be totally and permanently disabled, and given this unanimity of opinion the Retirement Board credited the conclusions of its neutral physicians over any contrary evidence.

AR 1373.

C. Procedural History

On October 16, 2015, Plaintiff filed his Complaint seeking review, under ERISA, of Defendant's denial of T&P benefits, and attorneys' fees. DE 1. On April 7, 2016, the parties jointly moved to stay this case. DE 21. As grounds, the parties explained that Plaintiff was "awaiting an imminent determination by the Social Security Administration as to his eligibility for Social Security Income (SSI) benefits" and that "[s]hould Plaintiff receive a favorable disability determination by the Social Security Administration, the parties agree that this would be dispositive of a material aspect of the claims asserted

by Plaintiff in this litigation." Id. ¶¶ 1-2. The Court granted the parties' motion to stay but required the parties to file periodic status reports on Plaintiff's claim for SSI benefits. DE 22. Plaintiff's claim for SSI benefits dragged on for approximately a year and a half. On November 20, 2017, Plaintiff filed a status report informing the Court that the Social Security Administration had recently issued a determination that Plaintiff is disabled under section 1614(a)(3)(A) of the Social Security Act. See DE 34-1 (the "SSA Award"). The Court then ordered the parties to participate in a second mediation, DE 42, but after the parties were unable to reach a settlement, DE 46, the Court lifted the stay on August 29, 2018. DE 47. The parties then filed their respective Motions on November 19, 2018. DE 52, 53.

D. Dispositive Motions

In his Motion, Plaintiff first argues that his SSA Award is dispositive of his right to T&P disability benefits. DE 53 at 4-5. Plaintiff also argues that Defendant's denial of T&P benefits was wrong and arbitrary and capricious. Id. at 5-31. As grounds, Plaintiff asserts that: (1) Defendant applied a more stringent standard for disability than contained in the Plan, (2) all seven Plan Neutral Physician evaluations were "fundamentally flawed and incomplete," (3) Defendant improperly "cherry-picked" the reports of the Plan Neutral Physicians to support its decision, and (4) Defendant arbitrarily refused to credit the medical and psychological reports submitted by Plaintiff. See id.

In its Motion, Defendant argues that the SSA Award is not dispositive of Plaintiff's right to T&P disability benefits and that the Board considered all of the evidence but, in

its discretion, reasonably decided to accept the unanimous conclusion of the seven Plan Neutral Physicians that Plaintiff is not totally and permanently disabled. See DE 52.

II. STANDARD OF REVIEW

As noted above, Plaintiff calls his Motion a "Dispositive Motion for Summary Judgment," DE 52, while Defendant calls its Motion a "Motion for Judgment on the Administrative Records." DE 53. The Eleventh Circuit has "recognized [that] the motion that serves 'as [a] vehicle[ ] for resolving conclusively' an ERISA benefits-denial actions is not a typical motion for summary judgment." Prelutsky v. Greater Georgia Life Ins. Co., 692 Fed. Appx. 969, 972 n.4 (11th Cir. 2017) (quoting Blankenship v. Metro. Life Ins. Co., 644 F.3d 1350, 1354 n.4 (11th Cir. 2011) (per curiam)). Rather, "[u]nlike the usual summary-judgment standard, the district court in the ERISA context 'does not take evidence, but, rather, evaluates the reasonableness of an administrative determination in light of the record compiled before the plan fiduciary.'" Id. (quoting Leahy v. Raytheon Co., 315 F.3d 11, 17-18 (1st Cir. 2002)). See also Reid v. Metro. Life Ins. Co., 944 F. Supp. 2d 1279, 1302 (N.D. Ga. 2013) (citing Curran v. Kemper Nat. Servs., Inc., No. 04–14097, 2005 WL 894840, at *7 (11th Cir. Mar. 16, 2005)) ("In an ERISA benefits denial case the district court acts more as an appellate court than as a trial court."). Thus, the Court will not apply the usual summary judgment standard here. See Leahy, 315 F.3d at 17 (quoted with approval in Blankenship, 644 F.3d at 1354 n.4) (discussing the "obvious discongruence" between the usual summary judgment standard and the arbitrary and capricious standard for ERISA cases).

The Eleventh Circuit has established a multi-step framework for Courts to apply in reviewing an ERISA plan administrator's benefits decision. Blankenship, 644 F.3d at

1355. Here, however, because the Board has full discretionary authority and no conflict of interest, the arbitrary and capricious standard of review applies, and the dispositive question is whether the Board's decision was reasonable. See Prelutsky, 692 Fed. Appx. at 973 ("even assuming that GGL's decision was '*de novo* wrong,' as the district court found, the dispositive question is whether GGL's decision was arbitrary and capricious.").

"When conducting a review of an ERISA benefits denial under an arbitrary and capricious standard (sometimes used interchangeably with an abuse of discretion standard), the function of the court is to determine whether there was a reasonable basis for the decision, based upon the facts as known to the administrator at the time the decision was made." Glazer v. Reliance Standard Life Ins. Co., 514 F.3d 1241, 1246 (11th Cir. 2008). If there is a reasonable basis, the decision "must be upheld as not being arbitrary or capricious, even if there is evidence that would support a contrary decision," White v. The Coca–Cola Co., 542 F.3d 848, 856 (11th Cir. 2008), or "[if] the court or anyone else might reach a different conclusion." Turner v. Delta Family–Care Disability and Survivorship Plan, 291 F.3d 1270, 1274 (11th Cir. 2002). The administrator's decision "need not be the best possible decision, only one with a rational justification." Griffis v. Delta Family-Care Disability, 723 F.2d 822, 825 (11th Cir. 1984).

III. ANALYSIS

A. The SSA Award Does Not Entitle Plaintiff to T&P Benefits

Plaintiff argues that his SSA Award is dispositive of his entitlement to T&P benefits based on: (1) Section 5.2(b) of the Plan and (2) Defendant's assertion to the Court in the parties' Joint Motion to Stay Proceedings that the SSA Award would be

"dispositive of a material aspect of the claims" in this case. DE 53 at 4-5. Section 5.2(b) of the Plan provides in relevant part that:

> An Eligible Player who is not receiving monthly pension benefits under Article 4 or 4A, who has been determined by the Social Security Administration to be eligible for disability benefits under either the Social Security disability insurance program or Supplemental Security Income program, and who is still receiving such benefits at the time he applies, will be deemed to be totally and permanently disabled, unless four voting members of the Retirement Board determine that such Player is receiving such benefits fraudulently and is not totally and permanently disabled.

AR 27.

Defendant argues that the SSA Award should not factor into the Court's analysis because it was generated over two years after the Board's final determination and is therefore not part of the administrative record. DE 52 at 19-20. Defendant explains that the SSA Award "was submitted to and treated as a new application under an entirely separate plan—the NFL Player Disability & Neurocognitive Benefit Plan ("Disability Plan")—***not*** the Retirement Plan." Id. at 20 (emphasis in original). The Disability Plan is not a party to this case. Based on the SSA Award, Plaintiff was found to be automatically entitled to "Inactive B" T&P benefits under the Disability Plan (he seeks more lucrative "Inactive A" benefits from Defendant). See DE 52-10. Defendant also argues that because Plaintiff did not seek further administrative review of the Disability Plan's decision and the time has elapsed for him to do so, he has failed to exhaust his administrative remedies and is therefore barred from seeking greater or additional benefits premised on the SSA Award. DE 52 at 20. Plaintiff does not respond at all to these arguments in his Response to Defendant's Motion or in his Reply.

The Court is troubled by Defendant's inconsistent positions with respect to the SSA Award. Defendant offers no explanation whatsoever for why, in April 2016, it

represented to the Court that the SSA Award would be "dispositive of a material aspect of the claims" in this case and then less than two-and-a-half years later claimed that the SSA Award was "not even relevant." DE 48 at 3. If the SSA Award is not relevant now, Plaintiff's claim for SSI benefits was never relevant to this litigation and was certainly no reason to delay this case for two-and-a-half years.

But while Plaintiff cites to Defendant's prior representation regarding the SSA Award in his Motion, DE 52 at 4-5, he fails to advance an estoppel argument. Even had he made such an argument, however, the Court would not accept it under the circumstances. That is because all that Defendant gained by representing to the Court that the SSA Award would be relevant was a temporary stay of the case—an outcome that Plaintiff jointly requested. See New Hampshire v. Maine, 532 U.S. 742, 750 (2001) (explaining that "judicial estoppel is an equitable doctrine invoked at a court's discretion" and that courts have inquired as to "whether the party seeking to assert an inconsistent position would derive an unfair advantage or impose an unfair detriment on the opposing party if not estopped.") (internal quotation marks and citations omitted).

Ultimately, despite concerns about Defendant's inconsistent positions with respect to the SSA Award, the Court agrees with Defendant that the SSA Award is not properly considered given that it is outside the administrative record and because of Plaintiff's failure to exhaust his administrative remedies with respect to the Disability Plan's treatment of the SSA Award. See, e.g., Blankenship, 644 F.3d at 1354 ("Review of the plan administrator's denial of benefits is limited to consideration of the material available to the administrator at the time it made its decision."); Springer v. Wal-Mart Associates' Grp. Health Plan, 908 F.2d 897, 899 (11th Cir. 1990) ("It is well-established

law in this Circuit that plaintiffs in ERISA cases must normally exhaust available administrative remedies under their ERISA-governed plans before they may bring suit in federal court.").

B. Defendant and the Plan Neutral Physicians Properly Applied the Plan

Plaintiff asserts that Defendant and all of the Plan Neutral Physicians "applied a more stringent standard for T&P disability than provided in the Plan." DE 53 at 17 n.8. Rather than considering whether Plaintiff has "the ability to work in any occupation for remuneration or profit," Plaintiff argues that the proper inquiry is whether Plaintiff "is unable to work in an occupation ***in which he could earn at least $30,000 per year***." Id. at 17 (emphasis added). As noted above, the Plan provides under its "General Standard" for "Determination of Total and Permanent Disability" that a Player is entitled to T&P benefits if the Board finds: "(1) that he has become totally disabled to the extent that he is substantially prevented from or substantially unable to engage in any occupation or employment for remuneration or profit," and "(2) that such condition is permanent." AR-27. Later in this same section, the Plan states that: "[a] Player will not be considered to be able to engage in any occupation or employment for remuneration or profit within the meaning of this Section 5.2 merely because such person… receives up to $30,000 per year in earned income." Id.

Defendant argues that the Plan does not define disability by whether a Player is capable of working in a job that earns him more than $30,000 per year. DE 55 at 9-10. According to Defendant, its disability standard based on the ability to engage in "any occupation or employment for remuneration or profit" is "a fairly typical . . . disability standard." DE 55 at 9. The $30,000 exception, Defendant explains, "accommodates

many Players who, after retiring from professional football, earn modest income from signing autographs, for example." Id. at 10 (further explaining that "[a] Player who earns less than $30,000 by signing autographs would not be automatically disqualified from applying for and receiving T&P benefits. If the medical evidence showed that he was capable of employment, however, he would not be eligible for T&P benefits under the 'any occupation' standard."). Defendant notes that its interpretation of Plan provisions is entitled to a high degree of deference. Id. (quoting Blankenship, 644 F.3d at 1355 n.6.).

The Court finds that the only reasonable interpretation of the Plan's disability standard is the interpretation advanced by Defendant. See Luton v. Prudential Ins. Co. of Am., 88 F. Supp. 2d 1364, 1370-71 (S.D. Fla. 2000) ("When construing the terms of an ERISA policy, ambiguity exists if the policy is susceptible to two or more reasonable interpretations that can fairly be made . . . Under ordinary principles of contract interpretation, the court must first examine the natural and plain meaning of the plan's language"). The plain language of the Plan clearly does not require the Board to determine whether a Player is capable of working in a job that earns him more than $30,000 per year. Rather, the disability standard is unambiguously based on the ability to engage in ***any*** paid employment. The $30,000 exception plainly does not alter that general standard, but merely provides that a Player will not automatically be precluded from satisfying it simply because he receives up to $30,000 per year in income.

While the Plan's plain language is unambiguous and dispositive of the issue, even if it were ambiguous, Defendant's interpretation is undoubtedly reasonable. It is not difficult to imagine the practical problems that would arise in applying Plaintiff's interpretation of the Plan's disability standard. Not only would the Board likely need to

weigh the expert opinions of physicians regarding a Player's physical and/or mental health, it would need to attempt to determine how a Player's physical and/or mental limitations would impact his ability to engage in specific occupations that pay above the $30,000 threshold (as well as presumably take into account regional pay differences).[3]

C. Defendant's Denial of T&P Benefits was not Arbitrary and Capricious

The Court finally turns to consider whether there is a reasonable basis in the administrative record for Defendant's determination that Plaintiff is not totally and permanently disabled. Given that the administrative record includes the comprehensive reports of ***seven*** Plan Neutral Physicians (including two orthopedists, two neurologists, two neuropsychologists, and one psychiatrist) that evaluated Plaintiff and ***unanimously*** concluded that he was capable of employment, it is clear that Defendant's decision to deny T&P benefits was not arbitrary and capricious. See, e.g., Boyd v. Bert Bell/Pete Rozelle NFL Players Ret. Plan, 410 F.3d 1173, 1179 (9th Cir. 2005) ("even a single persuasive medical opinion may constitute substantial evidence upon which a plan administrator may rely in adjudicating a claim."). Plaintiff's arguments to the contrary lack merit.

Plaintiff begins by arguing that Defendant's decision was wrong because of the record evidence showing that "during his career with the NFL, [Plaintiff] suffered multiple, severe injuries to most of his body, leaving him in chronic and debilitating pain." DE 53 at 5. Plaintiff points to the medical records he submitted in support of his

[3] Plaintiff also argues that the fact that Defendant reopened Plaintiff's claim—after initially denying it based on his admitted employment—when presented with evidence that Plaintiff was unable to earn up to $30,000 annually in his employment cuts against Defendant's interpretation. DE 59 at 11 n. 14. It does appear that, given Plaintiff's employment at the time of his application, Defendant was not required to reopen Plaintiff's claim merely because his annual income was less than $30,000. But although Defendant may have gratuitously done so, what matters is that when it did, it applied the correct disability standard in reaching its final determination.

application for T&P benefits as well as the reports submitted by both his physicians and the Plan Neutral Physicians. See, e.g., id. at 17 ("the majority of the evaluators hired by the Plan found clinical and objective evidence that [Plaintiff] suffers from cognitive deficiencies and severe psychological impairments."). But as Defendant correctly notes, the question is not whether Plaintiff has presented evidence that he has been diagnosed with certain impairments or even whether Plaintiff has presented evidence that could conceivably constitute a reasonable basis for finding him disabled. See, e.g., Sanzone v. Hartford Life & Acc. Ins. Co., 2008 WL 80984, at *11 (S.D. Fla. Jan. 3, 2008) ("whether Plaintiff is 'disabled' under the policy is not based on whether she has been diagnosed with a certain medical condition."); Crume v. Metro. Life Ins. Co., 417 F. Supp. 2d 1258, 1273 (M.D. Fla. 2006) ("[T]he pertinent question is not whether the claimant is truly disabled, but whether there is a reasonable basis in the record to support the administrator's decision on that point."). Thus, the Court assumes that Plaintiff's evidence could have supported a determination that he is disabled—as it did with respect to his claim for SSI benefits—but must confine its analysis to whether Defendant's decision to the contrary was reasonable.

As noted above, in attempting to establish that there was no reasonable basis in the record for Defendant's decision to deny T&P benefits, Defendant primarily argues that all seven Plan Neutral Physician evaluations were "fundamentally flawed and incomplete" and that Defendant arbitrarily refused to credit the medical and psychological reports submitted by Plaintiff. The Court will first address the various criticisms that Plaintiff lodges against the Plan Neutral Physicians.

First, with respect to Dr. Arlosoroff, Plaintiff argues that "[t]he fact that [Dr.] Arosoroff [sic] was not given any records to review renders his opinions incomplete and inherently unreliable." DE 53 at 17. Not so. Plaintiff cites no authority remotely suggesting that a physician's opinion based on a personal examination, medical history, and radiographic imaging cannot constitute a reasonable basis for a plan administrator's decision merely because of the physician's failure to review medical records.

Second, Plaintiff argues that all of the Plan Neutral Physicians "unreasonably assessed each of [Plaintiff's] conditions in a silo, failing to consider the cumulative effect of his physical, cognitive, and psychological symptoms on his functionality." Id. at 27. For example, Plaintiff faults Dr. McCasland, a neurologist, for confining his opinion to whether Plaintiff is able to work "from [a] neurologic standpoint." Id. at 17 (citing AR 887). The Court agrees with Defendant that the fact that the Plan Neutral Physicians limited their conclusions to areas within their expertise actually supports the reliability of their reports. And while Dr. Todd, Plaintiff's psychologist, opined on the combined effects of Plaintiff's psychological, physical, and cognitive impairments, it is unclear what qualified him to do so.

Plaintiff relies heavily on Maiden v. Aetna Life Ins. Co., 2016 WL 81489 (N.D. Ind. Jan. 6, 2016), but the Court finds Maiden unpersuasive and distinguishable. True, the Maiden court did fault the administrator for failing to "review[ ] the compound effect of Maiden's physical impairments and his psychiatric issues." Id. at * 6. But the court appeared most troubled by the fact that the administrator disregarded the opinions of the plaintiff's "primary care physician . . . therapist . . . pain management specialist . . . neurologist . . . surgeon . . . and [ ] psychiatrist" in favor of two of its physicians who

merely conducted file reviews. Id. at * 7 ("[e]ven within the silos of physical versus psychological disabilities, Aetna's review of Maiden's file is troubling."). Here, unlike in Maiden, the seven Plan Neutral Physicians actually evaluated Plaintiff and there is no indication that any of them, much less all seven of them, "failed to consider relevant aspects of [Plaintiff's] medical condition." Id.

Third, Plaintiff claims that the Plan Neutral Physicians "who were tasked with assessing [Plaintiff's] physical functional abilities came to drastically different conclusions" and that Defendant's failure to resolve these conflicts was unreasonable. DE 53 at 26. For instance, Plaintiff contrasts Dr. Canizares' opinion that Plaintiff could "conduct himself in a light duty work capacity" with Dr. Dunne's opinion that Plaintiff could only engage in sedentary employment. Id. at 30. Plaintiff further argues that Defendant's failure to resolve these allegedly conflicting opinions is especially unreasonable given Dr. Litchblau's FCE findings, which, according to Plaintiff, "resolve[s] the conflicts" and is the "the only objective testing of [Plaintiff's] functional ability." Id. at 16, 26.

The Court does not find that any arguable inconsistencies between the reports of the Plan Neutral Physicians rise to a level that would call the reliability of the reports into question. Not only do the seven Plan Neutral Physicians unanimously agree on the ultimate issue of Plaintiff's ability to work, but their specific conclusions do not significantly conflict. Consider the reports of the two Plan Neutral orthopedists: Dr. Arlosoroff opined that Plaintiff could "engage in any type of light to moderate duty work" and Dr. Canizares opined that Plaintiff could conduct himself in a "light duty work capacity." The fact that Dr. Dunne, a neurologist, opined that Plaintiff could engage in

sedentary employment that did not involve heavy lifting does not call into question the reliability of the opinions of any of the Plan Neutral Physicians. Nor does Defendant's failure to replicate Dr. Litchblau's FCE.

Plaintiff asserts that Dr. Litchblau's FCE provides "*unrefuted*, objective evidence of [Plaintiff's] functionality and inability to maintain gainful employment," DE 53 at 26 (emphasis in original), and that courts have recognized that FCEs are "the best means of assessing an individual's functional level." Id. (citing Lake v. Hartford Life & Acc. Ins. Co., 320 F. Supp. 2d 1240, 1246 (M.D. Fla. 2004)). But contrary to Plaintiff's claims, Dr. Litchblau's FCE is not unrefuted—it was refuted by Dr. Canizares, who reviewed the FCE and necessarily rejected its conclusions when he found Plaintiff capable of employment. AR 1257-58. Plaintiff cites Madison v. Greater Georgia Life Ins. Co., 225 F. Supp. 3d 1381 (N.D. Ga. 2016) in support of his argument that Defendant's "fail[ure] to consider, dispute, or replicate [the FCE] establishes arbitrary and capricious decision making." But comparing the facts of Madison to the facts of this case illustrates precisely why Defendant's decision was ***not*** arbitrary and capricious.

In Madison, the administrator based its decision to deny long-term disability ("LTD") benefits solely on the opinions of record reviewers, none of whom ever examined the plaintiff. Id. at 1394. As in this case, the plaintiff in Madison had obtained an FCE. See id. But two of the administrator's three record reviewers "had no chance to consider the FCE, and [Dr. William] Andrews, the only reviewer who had access to it, never mentioned the FCE in his report." Id. at 1394. Instead, the court found that Dr. Andrews "inexplicably focused almost entirely" on the only exam of the plaintiff that "showed no objective measurements of left knee deficiencies," despite "fifteen other

visits that showed at least some deficiency." Id. at 1394, 96-97. The Madison court ultimately held that "[s]uch a selective review of the evidence and reliance on a cold record file review by a non-examining doctor, to the exclusion of plainly relevant and reliable clinical evidence like Madison's FCE, establishes that [GGL's] decision was not made 'rationally and in good faith' and is therefore unreasonable." Id. at 1400 (internal quotations omitted). In stark contrast to Madison, Defendant's failure in this case to replicate or directly dispute the FCE does not render its decision arbitrary and capricious given that Defendant did not rely on the "selective review of the evidence" by non-examining doctors, but on the unanimous opinion of physicians that personally examined Plaintiff and necessarily rejected the conclusions of the Plaintiff's FCE.

Plaintiff raises several other criticisms of the Plan Neutral Physicians. For instance, he argues that their examinations were not sufficiently thorough and that they failed to conduct certain assessments that they should have. See, e.g., DE 53 at 17 ("Arlosoroff's 'examination' of Mr. Mickell lasted only a few minutes . . ."), id. at 23 ("Defendant failed to request and [Dr.] Faber failed to perform any mental status testing, a comprehensive psychological assessment . . . validity testing, or a formal assessment of response biases."). But the Court agrees with Defendant that these complaints "are not the type irregularities that create 'procedural unreasonableness' sufficient to recast [Defendant's] reliance upon the consulting professionals' opinions as being arbitrary and capricious." Howard v. Hartford Life & Acc. Ins. Co., 929 F. Supp. 2d 1264, 1297 (M.D. Fla. 2013).

Lastly, Plaintiff argues that Defendant arbitrarily refused to credit the medical and psychological reports submitted by Plaintiff. See, e.g., DE 53 at 25-26 (quoting Black &

Decker Disability Plan v. Nord, 538 U.S. 822, 834 (2003)) ("plan administrators '***may not arbitrarily refuse to credit a claimant's credible evidence***.'") (emphasis in original). Of course, Defendant points to the next sentence of the Supreme Court's Nord decision, which states: "[b]ut, we hold, courts have no warrant to require administrators automatically to accord special weight to the opinions of a claimant's physician; nor may courts impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation." Nord, 538 U.S. at 834. Here, Defendant reasonably credited the unanimous opinion of the seven Plan Neutral Physicians over the conflicting evidence that Plaintiff submitted. And as noted above, Plaintiff has failed to show that any, much less all, of the Plan Neutral Physician's reports are unreliable. Moreover, the Plan expressly gives the Board "full and absolute discretion, authority and power" to weigh evidence and determine benefits claims and states that "Neutral Physician reports . . . will be substantial factors" in the Board's decision-making. AR 41-42, 45, 50.

In sum, Defendant did not "simply ignore[ ] relevant medical evidence in order to arrive at the conclusion it desired," it "denied [Plaintiff's] claim . . . on the basis of conflicting, reliable evidence—a practice [the Eleventh Circuit] ha[s] upheld." Oliver v. Coca Cola Co., 497 F.3d 1181, 1199 (11th Cir. 2007), reh'g granted, opinion vacated in part, 506 F.3d 1316 (11th Cir. 2007), and adhered to in part on reh'g sub nom. Oliver v. Coca-Cola Co., 546 F.3d 1353 (11th Cir. 2008).

IV. CONCLUSION

For the foregoing reasons, it is **ORDERED** and **ADJUDGED** as follows:

1. Plaintiff's Motion for Summary Judgment [DE 53] is **DENIED**.

2. Defendant's Motion for Judgment on the Administrative Record [DE 52] is **GRANTED**.

3. The Court will enter a separate Final Judgment consistent with this Order.

DONE AND ORDERED in Chambers at Fort Lauderdale, Broward County, Florida, this 15th day of January, 2019.

Copies provided to counsel of record via CM/ECF

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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

CASE NO. 15-62195-CIV-COHN/SELTZER

DARREN MICKELL,

Plaintiff,

vs.

BERT BELL/PETE ROZELLE
NFL PLAYERS RETIREMENT PLAN,

Defendant.

_____/

FINAL JUDGMENT

THIS CAUSE is before the Court following its Order on Parties' Dispositive Motions [DE 60.] Accordingly, it is

ORDERED and **ADJUDGED** as follows:

1. Judgment is hereby entered in favor of Defendant the Bert Bell/Pete Rozelle NFL Player Retirement Plan and against Plaintiff Darren Mickell.

2. The Clerk of Court is directed to **CLOSE** this case and **DENY** any pending motions as **MOOT**.

DONE AND ORDERED in Chambers at Fort Lauderdale, Broward County, Florida, this 15th day of January, 2019.

JAMES I. COHN
United States District Judge

Copies provided to counsel of record via CM/ECF

Cert of SVC

CERTIFICATE OF SERVICE

I hereby certify that I caused the foregoing Appendix, Volumes I-VII to be served on counsel for Defendant-Appellee via Electronic Mail generated by the Court's electronic filing system (CM/ECF) with a Notice of Docket Activity:

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I certify that an electronic copy was uploaded to the Court's electronic filing system. Two paper copies of the foregoing Appendix, Volumes I-VII were sent to the Clerk's Office by Federal Express Next Business Day Delivery to:

Clerk of Court
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United States Courthouse
56 Forsyth Street, NW
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on this 10th day of May 2019.

/s/ Samantha Collins
Samantha Collins